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Mental health staff perspectives on supporting recovery

Le Boutillier, Clair

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MENTAL HEALTH STAFF PERSPECTIVES ON SUPPORTING RECOVERY

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Abstract

Background

Recovery has come to mean living a life beyond mental illness, and mental health services are encouraged to consider their role in supporting recovery. Staff perspectives are central to understanding how recovery support can be adopted in mental health care, because staff provide front-line services and are the vehicle bridging the gap between policy rhetoric and clinical practice.

Aims

To explore staff perspectives on supporting recovery and to identify factors that help or hinder their efforts to provide support for recovery.

Methods

A thematic analysis of 30 international documents offering recovery-orientated practice guidance was conducted. Ten focus groups were then conducted with multidisciplinary clinicians (n=34) and team leaders (n=31) from five NHS Mental Health Trusts across England, followed by individual interviews with clinicians (n=18), team leaders (n=6) and senior managers (n=8) using grounded theory methodology. A systematic review and narrative synthesis of empirical studies (n=22) identifying clinician and manager conceptualisations of recovery-orientated practice was then conducted.

Results

The synthesis of existing practice guidance identified four practice domains of recovery support: Promoting Citizenship, Organisational Commitment, Supporting Personally Defined Recovery, and Working Relationship. The grounded theory identified a core category of Competing Priorities, with subcategories Health Process Priorities, Business Priorities and Staff Role Perception. The contextualising systematic review identified three conceptualisations of recovery support: Clinical Recovery, Personal Recovery and Service-defined Recovery.

Conclusions

The conceptual framework of recovery-orientated practice contributes to the understanding of recovery-orientation. Competing priorities influence how recovery-orientated practice is understood and supported by staff. Service-defined recovery is a new and un-researched influence in mental health systems. The impact of service-led approaches to operationalising recovery in practice has not been evaluated.

Referencing and language used in the text

The Harvard referencing system is used in the text. If a supporting reference has three or more authors, the first author is cited followed by et al.

The thesis is written in the third person. The term "the author" refers to the PhD candidate and author of this thesis.

The terms "staff", "practitioner", "professional", "worker" and "provider" are used interchangeably to refer to people who work in a clinical capacity (paid or unpaid) in mental health services.

The terms "service user", "user of mental health services", and "consumer" are used interchangeably to refer to people who are using (or have used) mental health services.

The term "carer" is used to refer to family members, friends, advocates, and other unpaid supporters of people who access mental health services.

The term "personal recovery" refers to the ways in which a person who lives with mental illness experiences and manages his or her illness in the process of reclaiming a meaningful life.

The term "recovery-orientated" care refers to what mental health services and staff offer in support of a person's recovery.

Where referring to the work of others, the preferred terminology of the original authors is used.

All data have been anonymised.

Chapter 1. Introduction

This thesis explores mental health staff perspectives on supporting recovery. Chapter 1 provides the rationale and context for the research. It describes the research approach and study design, and explains the thesis structure.

Chapter 1 comprises six sections. The rationale for the study is outlined in Section 1.1, along with the background and impetus for the research. Section 1.2 describes the research context within which the study sits. Section 1.3 describes the approach used to conduct the study. Section 1.4 details the research aims and provides an outline of the study design. Section 1.5 outlines the thesis structure. Finally, Section 1.6 details the contribution of the author in conceptualising, designing, conducting and reporting the study.

1.1 The rationale and impetus for the research

The rationale and impetus for the research was built on three influences: the need for mental health services to support recovery, the need for research on staff perspectives on supporting recovery, and the author's personal motivation.

1.1.1 Supporting mental health recovery

This thesis addresses a call for mental health service transformation to provide support for recovery (Department of Health, 2011). A review of the background literature on mental health recovery and support for recovery is provided in Chapter 2. A brief overview is provided here to orientate the reader.

Two broad conceptualisations of mental health recovery have emerged. The first conceptualisation, called Clinical recovery, is based on the more traditional focus of mental health services. Clinical recovery is often measured in terms of symptomatology, and viewed as improvement in health outcomes such as a remission of symptoms and maintenance of basic functioning (Lieberman et al., 2008). The second conceptualisation, called Personal recovery, shifts the focus away from managing symptoms to supporting people to come to terms with, and overcome challenges associated with living with a mental illness, and to build a meaningful life (Davidson et al., 2005).

The focus of this thesis is on supporting the concept of personal recovery. Personal recovery builds on the traditional notion of clinical recovery by empowering individuals

who live with mental illness to manage symptoms and to control the effects of illness as well as to share decisions, achieve personal goals, actualise meaningful life roles and activities, and to develop a sense of identity beyond mental illness (Anthony, 1993). Although the personal recovery process for individuals goes beyond their contact with mental health services, it is likely that services will contribute to many people's recovery experience (Farkas, 2007). The need for this thesis was identified to address how personal recovery can be supported in mental health services.

1.1.2 The value of staff perspectives

Rose and colleagues (2006) advise that a multi-perspective evidence base is paramount in supporting adoption of innovations in practice, and that the perspectives of all key stakeholders need to be considered. While the perspectives of service users (those who access mental health services) on their recovery support is well-researched (Davidson, 2003), research on staff perspectives on supporting recovery is early-stage and in need of further development (Piat and Lal, 2012). The perspectives of carers (those who care for people who access mental health services) is also important (Marshall et al., 2013) and under-researched, but not addressed in this thesis.

In this thesis, the term "staff" is used collectively to refer to clinicians, team leaders and senior managers. The perspectives of staff are central to understanding how support for personal recovery can be adopted in mental health care because they provide and/or manage front-line services, and they are the vehicle which bridges the gap between policy rhetoric and clinical practice (Hardiman and Hodges, 2008). Existing research on staff perspectives is reviewed in Chapter 2.

1.1.3 Personal motivation

Bringing a clinical background to the research provided a personal and professional motivation for the study. The author graduated from Dorset House school of occupational therapy, Oxford Brookes University in 1995, where the training was founded on client-centred practice, holism and the therapeutic use of self (Duncan, 2012). The author worked alongside Dr Maureen Fleming while completing Masters level study at Boston school of occupational therapy, Tufts University in 1997. With a particular interest in the thinking behind the practice, the author was afforded the opportunity to build on earlier research (Mattingly and Fleming, 1994), and to consider the role of narrative reasoning (the stories clinicians share about their practice) on determining individual practice decisions. The focus of staff perspectives on supporting recovery built on the author's interest in clinical reasoning and how practice decisions

are made. An interest in supporting staff to move to more recovery-orientated styles of working, and in engaging staff in research, also provided incentive.

1.2 The context for the research

The study was conducted within a larger programme of research called the REFOCUS programme. REFOCUS was a 5-year study funded by the NHS National Institute for Health Research under the Programme Grants for Applied Research scheme (NIHR: reference RP-PG-0707-10040) from 2009 to 2014. REFOCUS aimed to develop an empirical evidence base of recovery-orientation, and to promote recovery-orientated community-based mental health services in England (Slade et al., 2011).

1.2.1 REFOCUS: Developing a recovery focus in mental health services in England

The overall aim of the research programme was to understand how, and to increase the extent to which, mental health services can support recovery.

The REFOCUS programme had four objectives:

1. To identify gaps between current and recovery-orientated practice and to understand why those differences exist
2. To develop a manualised and empirically defensible complex intervention to support recovery, based on an explicit and testable model
3. To identify or develop appropriate patient-level process and outcome measures
4. To evaluate the intervention in a randomised controlled trial.

The REFOCUS programme was a two-phase, mixed methods study, which took place in NHS Adult Community Mental Health Teams using the Care Programme Approach (Department of Health, 2008b) at six sites across England between 2009 and 2014. Phase one was organised into three modules: define the problem, optimise the intervention and optimise the evaluation. Although staff perspectives on supporting recovery is a topic which originally sat outside the scope of the REFOCUS programme, the research presented in this thesis was integrated into the *Define the problem* module.

Phase 2 involved the REFOCUS trial (ISRCTN02507940), a two-site cluster randomised controlled trial (RCT) of the REFOCUS intervention versus treatment as usual (Slade et al., 2015a). The implications of the research presented in this thesis,

and how the findings were subsequently used to inform the wider REFOCUS programme are reported in Chapter 7.

1.2.2 Adult community mental health services

Mental health is a priority area for the National Health Service (NHS) (Department of Health, 2013a). The context for the study was community-based mental health care provision for adults, provided by the NHS in England. NHS community mental health care is provided by a range of specialist multidisciplinary Community Mental Health Teams (CMHTs) that provide support to adults of working age (aged 18-65) living in the community with severe and enduring mental illness, including but not exclusive to psychosis (e.g. schizophrenia, schizo-affective disorder), mood disorder (e.g. bipolar disorder, depression), anxiety and personality disorder (Appleby, 2004). The range of CMHTs that provide specialist support include: Early intervention, Support and Recovery; Rehabilitation; Assertive Outreach and Forensic teams. The Care Programme Approach (CPA) was introduced in 1991 and provides a case management framework for community mental health care. It was revised in 2008 to reflect the focus for services on supporting recovery (Department of Health, 2008b). The CPA requires that a named staff member (care coordinator) is allocated to monitor and coordinate care and that service provision comprehensively assesses, plans and reviews the health and social care needs in collaboration with all individuals who access community mental health services.

Alongside the CPA framework, services are expected to follow practice guidelines that offer evidence-based advice on the care of adults living with mental illness. In England, The National Institute for Health and Care Excellence (NICE) provides guidance and advice to improve health and social care, and to reduce variation in the availability and quality of NHS treatments and care. The NICE guideline for schizophrenia was first published in 2002 (Clinical Guidance (CG) 1) and subsequently updated in 2009 (CG82) and again in 2014 (CG 178) (National Institute for Health and Care Excellence, 2014). The experience of mental health care received by service users (living with psychosis or schizophrenia) can also be improved by using NICE CG 136, which addresses service user experience in adult mental health (National Institute for Health and Care Excellence, 2011).

1.2.3 Position of staff researching staff

The author has extensive clinical work experience, and in 2004, she joined South London and Maudsley NHS Foundation Trust to provide occupational therapy

assessment, intervention and care coordination to adult community mental health teams and the Early Intervention Service (EIS). The author was also involved in corporate planning as a member of the Social Inclusion and Recovery (SIR) board. In 2009, she joined King's College London to work on the REFOCUS research programme at the Section for Recovery, Health Service and Population Research Department, Institute of Psychiatry, Psychology and Neuroscience. Bringing clinical work experience to a research worker role has been invaluable, but has necessitated the need to remain open and aware of how this might influence the research process (Barnes, 1996). For example, the author was aware of her potentially increased sensitivity to staff culture and therefore considered her own staff perspective on supporting recovery, and also reflected on previous experience of working in mental health services. Strategies used to examine the author's influence on shaping the research process are reported in Chapter 4.

1.3 Research approach

A qualitative approach was used to conduct the research. Qualitative research is valuable in exploring areas where little is known, in investigating diverse perspectives, in providing rich descriptions of complex phenomena, and in conducting initial explorations to develop theories (Patton, 1999).

Qualitative research methods describe the ways in which qualitative data are collected, organised and analysed. Most methods involve categorisation of the text into themes or categories, either inductively or deductively (Silverman, 2004). Qualitative research was considered appropriate for this study and the choice to use qualitative research methods was made based on:

- 1) The nature of the research aims. The study aimed to investigate staff perspectives through an in-depth exploration of how individuals conceptualise their views, and to begin to understand the context in which recovery support is delivered (Fossey et al., 2002).
- 2) The maturity of the concept, i.e. how much is known about the phenomenon to be investigated. Qualitative research typically adopts an open-ended, exploratory approach to understanding, explaining and generating broad generalisations and theories that is especially useful when little is known about a research topic (Cresswell, 1998).

1.4 Study design

The research aims and study design were inter-woven, and are therefore presented together.

1.4.1 The research aims

The broad research aim was to explore staff perspectives in relation to supporting recovery. The intention was to address the lack of existing knowledge within this population at this time. The focus of the research became more refined as data collection and analysis progressed. Two specific aims emerged:

Aim 1: To identify staff perspectives on factors that help or hinder their efforts to provide support for recovery

The first aim was to investigate the barriers and facilitators to supporting recovery in practice. This aim was flexible and used as a starting point. As the data collection and analysis progressed, the complexity of supporting recovery in practice emerged. One significant factor to emerge in the success of supporting recovery was staff understanding of recovery-orientated practice. Consequently, a second aim was added to explore staff perspectives on what recovery means in practice.

Aim 2: To investigate staff understanding of recovery-orientated practice

The lack of a shared understanding of what recovery means in practice emerged as an early finding. Equally, tensions between staff understanding of recovery-orientated practice and the practicalities of how staff were able to support recovery in practice were identified. The study subsequently focused on exploring staff understanding of recovery-orientated practice by investigating what workers say they do to support recovery.

1.4.2 Method

The research method also evolved as data collection and analysis progressed. The study began by synthesising existing practice guidance to develop a conceptual framework of recovery-orientated practice. The aim was to increase conceptual clarity about how recovery support can be operationalised in mental health services. The development process and resulting conceptual framework is reported in Chapter 3.

Ten focus groups were then conducted (five with staff and five with team leaders from community mental health teams) across five NHS mental health Trust sites in England. The initial aims of the focus groups were to identify barriers and facilitators to

implementing recovery-orientated practice, highlight areas of agreement and disagreement, and provide an initial understanding of participants' perspectives on supporting recovery. The focus group topic guide was developed before deciding on a suitable methodology and drew on existing implementation literature. It focused on three core questions; i) to explore what participants think helps implementation, ii) to explore what participants think hinders implementation, and iii) to explore what participants identify as potential solutions to implementation barriers. Prompts based on the Theoretical Domains Interview (Michie et al., 2005) were developed to support detailed discussion around the barriers and facilitators of implementation. The conceptual framework of recovery-orientated practice developed in Chapter 3 formed the basis of the initial focus group topic guide and was used to direct discussion. The conceptual framework is considered a heuristic one, and its intended use in the study was as a conversation guide for staff on what recovery might mean in practice. However, the conceptual framework of recovery-orientated practice was not reflective of early staff perspectives so was only used initially, and the research was instead led by the data. The focus group method is reported in Chapter 4.

Focus group data analysis identified a methodological limitation, where participants had difficulty in eliciting individual accounts of recovery-orientated practice in a group context. Individual interviews were therefore added to allow deeper probing to explore individual practice examples alongside barriers and facilitators to supporting recovery. The interview method is reported in Chapter 4.

1.4.3 The use of a grounded theory approach

The decision to use grounded theory was made following focus group data collection at the first site where it became apparent that there was no accepted understanding of how recovery is, or can be, translated into practice and because staff perspectives on supporting recovery are relatively unexplored. Grounded theory methodology was therefore selected as most appropriate because it offered a systematic and rigorous methodology in an area where there is a dearth of research. Grounded theory research also aims to explore variation and accommodates diverse perspectives of participants (Cresswell, 1998). It was felt that this feature would be advantageous considering the multiple conceptualisations of recovery-orientated practice. Grounded theory studies extend beyond preliminary, exploratory or descriptive research to the generation of theory (Anells, 1996). The decision to develop a new theory was also made following consideration of existing theoretical frameworks of implementation (Michie et al., 2005), and the applicability of the frameworks to implementing recovery-orientated practice

(described in Section 2.4). The use of grounded theory methodology was also feasible to integrate into the wider REFOCUS programme.

The aim of grounded theory methodology is to generate theory that is "grounded" empirically in the collected data in order to reflect the reality of participant accounts. Research questions are therefore generated empirically from data in contrast to experimental research, where empirical work is designed to test a pre-defined hypothesis derived from a theory or model. Grounded theory research begins with a broad research aim and what is relevant to the topic is allowed to emerge. Research aims are defined more specifically over time to ensure sensitivity to the emerging theory by addressing what is relevant to the area (Strauss and Corbin, 1990). As previously noted, the investigation therefore started with the barriers to and facilitators of implementing recovery orientated practice in NHS community based health care as an area of study, and what was relevant was allowed to emerge. Hypotheses were generated inductively from the data and tested with further data collection (Strauss and Corbin, 1990). A second aim was added when preliminary focus group findings identified differences in the translated meaning of recovery into practice.

Early reflection on focus group data also highlighted the problem of identifying barriers and facilitators at the individual practice level. The groups were willing to share thoughts and perspectives collectively, but were less likely to share individual examples of recovery-orientated practice. To address this gap, additional semi-structured individual interviews were conducted. Preliminary focus group analysis informed an initial semi-structured individual interview schedule. The interview schedule focused on using practice examples of recovery orientation to identify blocks and enablers to implementation, gathered participants' views on incorporating recovery in to their routine clinical practice, and followed theoretical issues identified in the focus groups. The interview schedule was modified following interim analysis to further explore consistent themes and deviant cases as they emerged and to generate hypotheses.

Theoretical sampling was used to identify interview participants. Theoretical sampling draws on data analysis to guide further data collection to develop emerging concepts and theoretical issues (Strauss and Corbin, 1990). Differences in the sample such as models of service delivery (early intervention, assertive outreach, recovery) or core professions (psychiatrists, CPNs, occupational therapists) were explored and data collection continued until theoretical saturation was reached. The chosen variation of

grounded theory methodology is reported in Chapter 4. The grounded theory findings are reported in Chapter 5.

Grounded theory methodology suggests placing limits on reading in the early stages of the research process, and using literature after data analysis to ensure the developed theory is grounded in the data (Strauss and Corbin, 1990). A systematic review was therefore conducted following analysis of staff participant accounts and was used to extend the developed theory. While conducting a systematic review in the context of grounded theory methodology is not considered necessary (Strauss and Corbin, 1990), the decision to conduct a comprehensive review and synthesis of all available evidence was made as early scoping searches identified few existing studies on staff understanding of recovery-orientated practice. Narrative synthesis was used for analysis due to the qualitative research designs of included studies (Popay et al., 2006). The systematic review and narrative synthesis is reported in Chapter 6.

The final research design is shown in Figure 1.1.

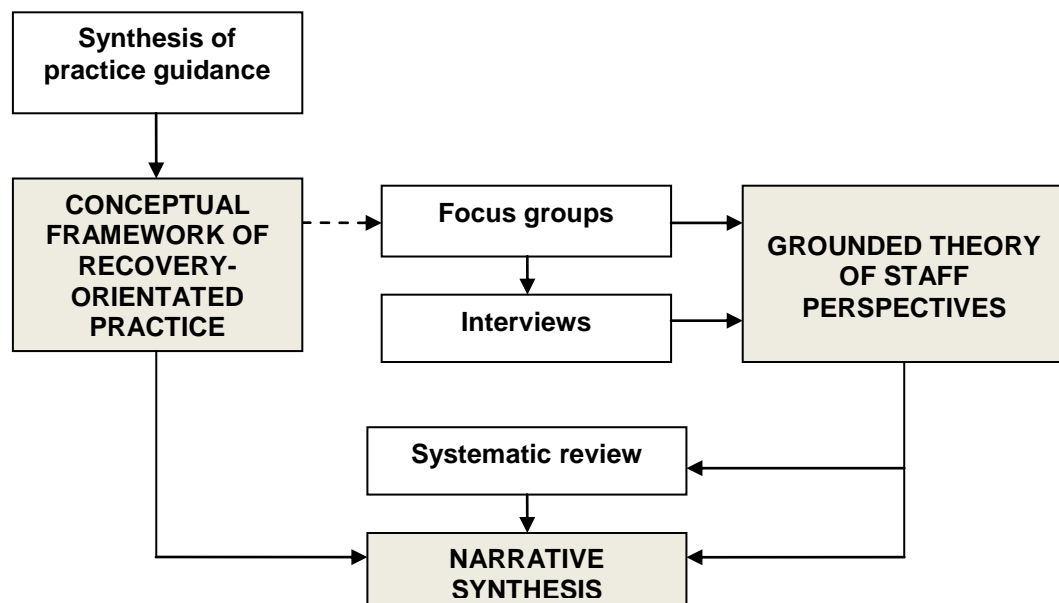


Figure 1.1 Research design

1.5 Organisation of the thesis

This thesis follows a chronological format. As noted, in line with grounded theory methodology, the systematic review was undertaken after the development of theory, with the aim of contextualising the findings. This literature is therefore reported after the

qualitative study of staff perspectives and not before, as is more typical in empirical research studies.

Chapter 2: Recovery and mental health services

Chapter 2 provides a narrative review of relevant literature on recovery and recovery-orientated practice and provides the background for the study. It details definitions, presents a critique of recovery, and provides the rationale for the research.

Chapter 3: A conceptual framework of recovery-orientated practice

Chapter 3 reports the development of a conceptual framework of recovery-orientated practice. The synthesis of guidance documents contributes to the understanding of what recovery might mean in practice.

Chapter 4: Grounded theory methodology and methods

Chapter 4 restates the study rationale and presents the grounded theory methodology and the qualitative methods used to explore staff perspectives on supporting recovery.

Chapter 5: Competing Priorities

Chapter 5 presents and discusses the grounded theory findings. The grounded theory method and results are reported in separate chapters to afford prominence to staff perspectives on supporting recovery.

Chapter 6: Service-defined recovery: Staff understanding

Using the grounded theory as a framework for analysis, Chapter 6 presents a systematic review and narrative synthesis of staff understanding of recovery-orientated practice.

Chapter 7: Synthesis and discussion of findings

Chapter 7 integrates the study findings and draws together the conceptual framework of recovery-orientated practice, grounded theory of staff perspectives and systematic review. Scientific and clinical implications are also presented. The overall strengths and limitations of the study are reported, and reflections are made on the directions for future research. It also details the contributions to knowledge made by the study.

1.6 Author contribution

The author reviewed the literature on recovery and recovery-orientated practice reported in Chapter 2.

For work reported in Chapter 3, the author conducted the literature search and thematic analysis of existing international recovery-orientated practice guidelines. With the support of additional analysts, she developed the conceptual framework of recovery-orientated practice.

For Chapter 4, the author designed the focus group sampling strategy and all focus group topic guides. She led focus group participant recruitment across four NHS Trust sites through communication with, and by providing support to local gate keepers. She recruited all staff and team leader participants at the fifth site and moderated 9 of 10 focus groups. She designed the interview sampling strategy and all individual interview schedules. She recruited 29 out of 32 interview participants across four NHS Trust sites and conducted 21 of the interviews. She accessed all sound files and re-read all transcripts to ensure accuracy.

For Chapter 5, with the support of additional analysts, the author conducted the grounded theory analysis.

For Chapter 6, the author applied for additional funds and was awarded £20,000 from the King's College London Parenting Fund for research support to conduct a systematic review. A six month full-time research worker post was funded to specifically assist with the systematic review component of this study. The author managed and supervised the research worker. The author designed the systematic review search protocol and supervised the scoping and final electronic literature searches. She sifted and assessed eligibility of a random 20% of the papers identified in the database search (n=2,033) to ensure reliability of inclusion and conducted all other searches (e.g. internet, hand searching etc). She extracted and tabulated data from, and decided on eligibility of selected studies (n=245) and conducted quality assessment on included studies (n=22). Due to the qualitative research designs of included studies, she chose to use narrative synthesis for analysis. She led the analysis, and conducted tabulation, thematic analysis and vote counting.

The author wrote the text in this thesis and she is first author for resulting publications (Le Boutillier et al., 2011, Le Boutillier et al., 2015a, Le Boutillier et al., 2015b). Publications resulting from the study are presented in Appendix 21.

Chapter 2. Recovery and Mental Health Services

Chapter 2 provides a narrative review of relevant literature on recovery and recovery-orientated practice, and provides the background and rationale for the study. It provides context by describing the concepts of recovery and recovery-orientated practice alongside the role of, and challenges for, mental health services in supporting recovery.

Chapter 2 comprises five sections. Section 2.1 reports the complex construct of recovery which has emerged in the mental health system and distinguishes between clinical and personal recovery. Section 2.2 details the responsibility of mental health services to promote personal recovery and acknowledges the complexity of introducing a new paradigm to practice. Section 2.3 reviews research on staff perspectives on supporting recovery. Section 2.4 provides a discussion of general factors affecting the success of implementation and highlights the complexity of operationalising recovery in practice. Finally, Section 2.5 provides a conclusion and highlights the implications for the thesis. It identifies the need for a conceptual framework of recovery-orientated practice.

2.1 What is Recovery?

Although the term "recovery" has been in use in mental health care since the 19th century (Kraepelin, 1919, Perceval and Bateson, 1961), it has been given stronger prominence more recently following the rise of consumerism (Chamberlin, 1978). Various meanings of recovery co-exist and different usages of the term suggest that recovery is a nebulous construct (Watson, 2012). Davidson and Roe (2007) write; *'There is an increasing global commitment to recovery as the expectation for people with mental illness. There remains, however, little consensus on what recovery means in relation to mental illness'* (p.459) (Davidson and Roe, 2007).

Recovery has been conceptualised in many ways. Recovery has been described as a paradigm, an ideology, a movement, an approach, a philosophy, an attitude, a model and a framework (Jacobson, 2004, Silverstein and Bellack, 2008, Rudnick, 2012). Recovery has been identified as both an experience, and as a guiding value for mental health services. Recovery has been conceptualised as both an internal and/or an external process, a journey and/or an outcome, and a clinical and/or a socio-political goal (Watson, 2012, Jacob et al., 2015).

A number of frameworks for understanding recovery have been proposed providing further evidence of diverse conceptualisations (Andresen et al., 2011). For example, multidimensional models (Whitley and Drake, 2010), frameworks of recovery as an individual experience (Henderson, 2011), as a process (Jacobson and Greenley, 2001, Song and Shih, 2009), and as a social and/or political issue (Hopper, 2007, Tew, 2013) exist. Equally, diverse terms are used to portray recovery including: "psychological recovery" (Andresen et al., 2003), "social recovery" (Warner, 2003), "social and functional recovery" (Lloyd et al., 2008), being "in recovery" (Davidson et al., 2008), "life" recovery (Collier, 2010), and "existential recovery" (Whitley and Drake, 2010).

Despite the multitude of views on the meaning of recovery, this chapter focuses on two broad conceptualisations that have emerged: Clinical recovery and Personal recovery. Clinical recovery predominantly aligns with a biomedical or clinical understanding, when someone recovers from mental illness and no longer experiences symptoms (Pilgrim, 2008). Personal recovery promotes an understanding led by people who live with mental illness, when someone recovers a life worth living with, or without symptoms of mental illness (Anthony, 1993). These two conceptualisations can also be viewed on a functional spectrum whereby clinical recovery focuses on limitations associated with disability and personal recovery focuses on possibilities for living well (Slade and Longden, 2015).

2.1.1 Clinical recovery

Clinical recovery is based on the more traditional focus of mental health services, typically aligned with a chronic disease model of care (Wagner et al., 1996). This framework is also widely adopted in the management of common chronic illness such as diabetes, depression and heart failure (<http://www.improvingchroniccare.org>) and has a primary focus on evidence-based interventions (Frese et al., 2001, Brown et al., 2008).

Clinical recovery is often measured in terms of symptomatology, and viewed as improvement in health outcomes such as a remission of symptoms and maintenance of basic functioning (Liberman and Kopelowicz, 2002, Mueser et al., 2003, Lloyd et al., 2008). For example, return to a "normal" state, as judged by mental health professionals is common to this conceptualisation of recovery (Slade, 2009b). Recommended criteria for measuring the success of clinical recovery include: engagement in full-time or part-time work or school, living independently without supervision, being not fully dependent on financial support from disability insurance,

and having friends with whom activities are shared on a regular basis. For clinical recovery rather than simply remission to be achieved, each criteria needs to be sustained, for example for at least two consecutive years (Lieberman et al., 2002).

2.1.2 Personal recovery

Personal recovery is based on first-person narratives of individuals who live with or have lived with mental illness, and challenges the notion of chronicity associated with severe mental illness (Lester and Gask, 2006). Personal recovery supports the rights and values of personhood and involves fundamental elements of justice and respect to which all people are entitled (Atterbury, 2014). Personal recovery has been described as the subjective process of taking control of one's life and one's illness, having optimism for the future and taking personal responsibility for one's own recovery (Roberts and Wolfson, 2004). Anthony (1993) defines recovery as *'a deeply personal, unique process of changing one's attitudes, values and feelings, goals and skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of a new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness'* (p.21).

Narratives of those with personal experience of mental illness describe personal recovery as an attitude and a way of approaching challenges (Deegan, 1996). Analysis of personal accounts suggests that recovery is a philosophy and a change of values and thinking, something experienced rather than something done to a person (Jacobson and Greenley, 2001). Personal recovery is a unique, personal self-directed process of transformation, and discovery of a new self to overcome mental illness and reclaim control and responsibility for one's life decisions (Mountain and Shah, 2008). It is a journey of hope and empowerment, self-determination, meaning and purpose (Onken et al., 2007). People use both internal and external sources of support, develop their own inner resilience and coping strategies (Meddings and Perkins, 2002), and draw on their strengths (Bird et al., 2012, Tse et al., 2016), the support of their environment and people close to them (Tew et al., 2012).

2.1.3 A conceptual framework of Personal recovery

Because personal recovery is rooted in individual experience, it is understood in a number of ways (Davidson et al., 2010), and therefore, a need for conceptual clarity on personal recovery has been identified (Warner, 2009). Alongside the need for conceptual clarity, a common criticism of personal recovery has also been the lack of a

scientific theory base (Lieberman et al., 2002). Definitions of personal recovery stress the unique and personal nature of each recovery experience, which does not align well with the drive towards evidence-based practice where there is a need to operationalise terms and to define the outcomes of interest. One way to address this evidence gap was through the creation of a conceptual framework of recovery, to provide a comprehensive understanding of the phenomenon, and to define and operationalise the term.

The author contributed to a systematic review and narrative synthesis of studies describing conceptualisations, models and theories of personal recovery that was conducted as part of the REFOCUS programme of research (summarised in Section 1.2) (Leamy et al., 2011). Electronic database searching, hand searching and web based searching were undertaken to identify relevant studies. Included papers were quality assessed using the RATS qualitative research review guidelines (Godlee and Jefferson, 2003) and the Effective Public Health Practice Project (EPHPP) quality assessment tool (Effective Public Health Practice Project, 2009).

Ninety seven papers were included in the review and 87 distinct studies were identified and synthesised. The resulting conceptual framework comprised three inter-linked, overarching categories: characteristics of the recovery journey, recovery stages, and recovery processes. Characteristics of the recovery journey comprised thirteen commonly identified experiences of recovering: Recovery as an active process; Individual and unique process; Non-linear process; Recovery as a journey; Recovery as stages or phases; Recovery as a struggle; Multi-dimensional process; Recovery as a gradual process; Recovery as a life-changing experience; Recovery is possible without cure; Recovery is aided by supportive and healing environment; Recovery can occur without professional intervention; and Trial and error process.

The review identified that recovery narratives are consistent with a stages model, whereby recovery is a continuous and unfolding process rather than a one-off experience or end product. Five recovery processes were identified as dimensions of change which typically occur during recovery; Connectedness, Hope and optimism, Identity, Meaning and purpose in life and Empowerment (giving the acronym CHIME and being called the CHIME framework from here on in this thesis). Connectedness relates to the connections, relationships and social support individuals have with other people, as well as connections to the wider community and to society as a whole. Different types of support were incorporated within the connectedness category,

including peer support, support from professionals, and support from the community, family and friends. Hope and optimism were identified as fundamental to the process of recovery. Individuals living with mental illness need to have hope and a belief in their own recovery, as well as a belief from others that things would get better. Identity refers to the process of overcoming mental illness, and of redefining and rebuilding a positive sense of identity. Meaning and purpose in life relates to finding a purpose in life as well as finding meaning associated with the mental illness experience. Different ways individuals could find meaning were incorporated within the category, including through social roles, goals, employment and meaningful activities. Empowerment relates to having a sense of empowerment within mental health services (such as having control over treatment and having personal responsibility), as well as becoming an empowered member of society.

The CHIME framework is based on retrospective reports of people reflecting on their personal recovery. To investigate the applicability of the CHIME framework to people currently using mental health services (i.e. who may be at an earlier stage of recovery), seven focus groups with current service users (n=48) from three mental health NHS Trusts in England were conducted. Participants were asked about their understanding and experience of personal recovery. Both deductive (the CHIME coding framework) and inductive analysis (to identify new themes) was used. CHIME was found to be relevant to current mental health service users, alongside additional emphasis on practical support, diagnosis and medication, and scepticism surrounding recovery (Bird et al., 2014b).

The international applicability of the CHIME framework was also assessed to address the concern that personal recovery is an Anglophone concept (Cox and Webb, 2015). The original systematic review was updated and further analysis was conducted. The review identified 105 theories and models of personal recovery from 11 countries. CHIME recovery processes were consistently found in the included international studies, indicating some cross-cultural validity. However, the review showed that most current evidence comes from Western and English-speaking countries, so caution is needed in generalising the recovery construct to non-majority populations (Slade et al., 2012).

The focus of this thesis is on supporting personal recovery. From here on, the terms "recovery" and "personal recovery" are used interchangeably.

2.2 The role of Mental Health Services in Supporting Personal Recovery

There is a policy and professional consensus about the importance of supporting recovery in mental health services and mental health services are encouraged to consider their role in supporting the personal recovery of individuals who experience mental illness (Department of Health., 2011, Mental Health Commission, 2005, New Freedom Commission on Mental Health, 2005, Mental Health Commission of Canada, 2012, Australian Health Ministers, 2012, Australian Health Ministers' Advisory Council, 2013, Mental Health Commission, 2012). Although the recovery process for many individuals goes beyond their contact with mental health services, it is likely that services will contribute to people's recovery experience (Farkas, 2007).

Mental health policy in the UK provides the objective for services to support people who live with mental illness to have '*greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live*' (p.21) (Department of Health., 2011). The importance of addressing personal recovery is now also supported in guidance for all key professions (Royal College of Psychiatrists, 2008, Department of Health, 2006, College of Occupational Therapists, 2006, Kinderman and Cooke, 2000).

While mental health services are encouraged to support the recovery of individuals living with severe mental illness (Department of Health., 2011) by transforming services towards a recovery orientation (Bracken et al., 2012), implementing the recovery orientation vision in mental health systems is challenging. Consensus on a definition of recovery is a prerequisite of recovery-orientated services so the co-existence of different frameworks of personal recovery (as discussed in Section 2.1) creates complexity when translating recovery to practice. Adding to this complexity is the introduction of personal recovery as a paradigm shift for mental health services (Pilgrim and McCranie, 2013).

2.2.1 Recovery as a new paradigm

A paradigm is a worldview; a lens shaped by shared assumptions, values, and practices (Kuhn, 1962). This thesis is based on the view that recovery is a rich concept that spans across health system levels. Recovery is more than a policy, more than a simple or complex intervention, and more than the values and attitudes of the workforce (Jacobson and Greenley, 2001). In this sense, recovery can be understood as a paradigm, in other words, a lens for mental health practice.

A paradigm shift is a fundamental change in worldview that replaces the former way of thinking and doing with a radically different way of thinking and doing (Kuhn, 1962). Supporting recovery involves a paradigm shift that repositions practice towards the subjective lived experience of those with mental illness (Bracken and Thomas, 2005). Personal recovery values the unique knowledge base of individuals who live with mental illness, as opposed to relying on professional expertise (Corrigan et al., 2005). Where previously the patient perspective may have been peripheral to practice (Goffman, 1961), the individual experience of those living with mental illness and accessing services moves to become the priority of practice (Kogstad et al., 2011).

Personal recovery offers a transformational ideology for services, and suggests reforms in how mental illness is understood and managed as well as how people living with mental illness are understood and helped (Farkas, 2007). This guiding philosophy challenges the ideas and beliefs about the aetiology and treatment of mental illness, including the way that mental health practice is organised and delivered to ensure people living with mental illness are allowed opportunities and resources to lead meaningful and productive lives (Davidson et al., 2005). This vision values greater independence of people living with mental illness and adopts a shift from paternalistic mental health practices to practices that support autonomy, agency and opportunity (Davidson et al., 2010). Personal recovery can be regarded as a working style that empowers people to manage symptoms and to control the effects of illness as well as to share decisions, achieve personal goals, actualise meaningful life roles, and develop a sense of identity beyond mental illness (Slade, 2009b). As Mueser and colleagues (2002) have noted; *'People with mental illness can participate actively in their own treatment and can become the most important agents of change for themselves'* (p.1282) .

The overarching aim of the recovery vision for services is to redefine the long-term prognoses of people with severe and enduring mental illness (Hyde et al., 2014). Attention is given to the recognition that there is more to a person than illness and primacy is given to each person in determining the stage and direction of their own individual recovery journey (Oades et al., 2005).

One challenge for service provision is viewing professional input and treatment as a means and not an end, thereby shifting the direction of practice from an outcome orientation to one of process (Macpherson et al., 2016). A further challenge is the

traditional emphasis in professional training that has focused on symptoms rather than the person, problems rather than strengths, minimising risk of harm rather than supporting therapeutic risk taking, and giving attention to illness rather than wellbeing (Rosen and O'Halloran, 2014). It has been suggested that embedding recovery in routine practice requires system transformation, implying that progress will not be made unless there is a fundamental paradigm shift in mindset and in practice (Brown et al., 2010). A practice shift is required if recovery is to be the primary focus of mental health care and recovery-orientated styles of working are to become routine (Shepherd et al., 2010).

2.3 Staff perspectives on the process of supporting Recovery

The perspectives of staff are central to understanding how support for personal recovery can be adopted in mental health care because they provide and/or manage front-line services, and they are responsible for interpreting and implementing pro-recovery policy into practice (Hardiman and Hodges, 2008). Research suggests that although the concept of recovery has been rhetorically embraced by mental health practitioners, actual adoption of recovery in practice remains mixed (Piat and Lal, 2012, Cleary et al., 2016). While research measuring levels of recovery-orientated practice in mental health services is becoming more commonplace (Ranz and Mancini, 2008, Corlett and Miles, 2010, Brown et al., 2010, Tsai and Salyers, 2010, Kidd et al., 2010, Leamy et al., 2014) and there is an emerging literature on staff knowledge, attitudes and perceptions of their recovery-orientated practice (Cleary and Dowling, 2009, Klockmo et al., 2012), an early scoping literature review (Levac et al., 2010) identified only one empirical study of staff perspectives on the process of supporting recovery. Whitley and colleagues investigated the opinions and experiences of program leaders on implementing the Illness Management and Recovery program, which is an illness self-management approach (described in Section 2.4) for people with severe mental illness (Mueser et al., 2002). Their study involved twelve public-sector community mental health agencies in the United States. Qualitative interviews were conducted at six month intervals over a two year period, with additional observation and field notes to enhance rigour. Barriers and facilitators to the implementation of the illness management and recovery program (IMR) were identified through content analysis. Four broad themes that influenced the success of implementation emerged: leadership, innovative organisational culture, effective training, and committed staff (Whitley et al., 2009). These findings mirror factors affecting the success of implementation of IMR identified in an earlier study of the perspectives of multiple stakeholders (including state mental health staff and community providers, commissioners, service users, carers and

advocacy volunteers) (Isett et al., 2007). This earlier study identified leadership as most critical given the fundamental shift of practice where a person who accesses mental health care moves from being '*a passive or marginally involved treatment recipient to a full partner in decision making about treatment*' (p.918). A high level of clinical skill was also identified as a requirement to deliver IMR effectively and it was considered that this might be difficult to achieve given the high staff turnover rate within the workforce (Isett et al., 2007).

Since the early scoping literature review, a study in Canada investigated the influence of organisational decision makers (n=10) on the implementation of recovery-orientated services (Piat et al., 2010). Semi-structured interviews were conducted and thematic analysis was used for analysis. Participants viewed front-line providers as pivotal in implementing system change and described their own role as limited to providing recovery orientation and funding. The authors concluded that the shift to recovery orientation must include '*active leadership from decision makers as a catalyst to change*' (p.168) (Piat et al., 2010).

More recently, the same group explored service providers' experiences and perspectives on recovery-orientated reform in Canada (Piat and Lal, 2012). This study involved nine focus groups at three sites and investigated the perspectives of 68 front-line staff. Analysis identified three major themes: 1) expressing positive attitudes towards recovery-oriented reform; 2) expressing scepticism towards recovery-oriented reform; and 3) experiencing challenges with the implementation of recovery-oriented practice. Positive attitudes included a radical change and a better way of delivering services, a change in power relationships, and a conceptual foundation to unite stakeholders. Negative attitudes included a political fad/just another buzz word and doesn't contribute anything new to practice. The implementation challenges related to conceptual uncertainty and consistency regarding the meaning of recovery, societal stigma and social exclusion of people who live with mental illness, institutional practices and the bureaucratisation and mandating of recovery-orientated tools, limited organisational leadership, and limited training and support (Piat and Lal, 2012). The need for clarity in operationalising recovery for practice reaffirms the findings of another study which identified the uncertainty of what recovery means in practice as a challenge to fidelity assessment (Armstrong and Steffan, 2009).

The need for training is further confirmed in the findings of a study with community mental health nurses' (n=23), whereby a gap was identified in the confidence in

understanding recovery orientation and in perceived ability to support recovery orientation (Gale and Marshall-Lucette, 2012). Emerging evidence suggests that staff training can improve pro-recovery attitudes (Crowe et al., 2006, Salgado et al., 2010, Gudjonsson et al., 2010, Wilrycx et al., 2012, Wilrycx et al., 2015) and knowledge (Peebles et al., 2009, Meehan and Glover, 2009) and support staff to implement recovery-orientated styles of working (Kymalainen et al., 2010, Tsai et al., 2011, Salkeld et al., 2013). For example, low fidelity scores for the illness management and recovery program (IMR) were initially reported (McHugo et al., 2007), but scores improved with additional training (Salyers et al., 2009). However, it has recently been noted that training may be insufficient unless the wider context in which mental health services are delivered are also addressed (Simpson et al., 2016).

If full implementation of the policy focus on recovery orientation is to become routine in clinical services, it is essential that the perspectives of staff are investigated (Rose et al., 2006). Although the evidence base is growing, it is early-stage and in need of further development (Piat and Lal, 2012). The lack of existing research provides a rationale for this thesis as there is a need to explore staff perspectives on supporting recovery to better understand the determinants of incorporating recovery support into routine front-line practice. The grounded theory methodology and methods used to collect staff perspectives are reported in Chapter 4. The findings are reported in Chapter 5.

2.4 Implementation challenges

Despite research on the diffusion of innovations (Rogers, 2003) and the growing discipline of implementation science (that is, the study of methods to promote the integration of research findings and evidence into healthcare policy and practice), a translational gap remains between scientific knowledge and routine implementation of healthcare innovations (Fixsen et al., 2005, Tansella and Thornicroft, 2009). While theories, models and frameworks are used to provide understanding and explanation, and to make sense of how and why attempts to translate evidence into practice might succeed or fail (Nilsen, 2015), research has predominantly focussed on implementing guidelines (Forrest et al., 1996, Cabana et al., 1999, Espeland and Baerheim, 2003, Michie et al., 2007) and evidence-based interventions (Torrey et al., 2001, Gravel et al., 2006, Kirsh et al., 2008, Aarons et al., 2009, Goderis et al., 2009, Mancini et al., 2009, May, 2013). Studies that use implementation strategies to support cognition (Lomas, 1993, Godin et al., 2008) and behaviour change (Iles and Sutherland, 2001, Grimshaw et al., 2002, Eccles et al., 2005, Hakkennes and Green, 2006, Michie et al., 2014,

O'Brien et al., 2014) also exist, but research on supporting individuals and organisations to shift paradigms is less common (Park et al., 2014, Park et al., 2015).

Implementation is a social process that is intertwined with the context in which it takes place. Therefore, success at supporting recovery may be influenced by factors at multiple ecological levels of the health care system (Von Bertalanffy, 1969); in the individual, social, organisational, economic and political context or by service users' beliefs or behaviour (Greenhalgh et al., 2004, Grol and Wensing, 2004, Damschroder et al., 2009, Shepherd et al., 2010). For example, at the individual level, staff attitudes on recovery have been identified as one factor influencing the success of guideline implementation (Prytys et al., 2011). A commitment from staff and effective training have also been identified as essential implementation support strategies (Whitley et al., 2009, Piat and Lal, 2012). At the organisational level, innovative organisational culture (Whitley et al., 2009), leadership (Whitley et al., 2009, Piat and Lal, 2012) and institutional practices (e.g. bureaucratisation of recovery-orientated tools) (Piat and Lal, 2012) have been shown to influence implementation of recovery support. Additionally, Ramon (2011) states that the organisational level is fundamental in promoting recovery orientation and in adopting a multi-level shift in values, knowledge and skills. She suggests that organisations need to become good learning organisations (Senge, 1990) by building a shared organisational vision, developing systemic thinking, and challenging existing models of practice (Ramon, 2011). Clossey and colleagues (2011) suggest that appreciative inquiry (exploring and discovering the strengths, successes and possibilities of organisations and being open to seeing new potentials of organisations) has the power to shift dominant organisational cultures and can facilitate the implementation of recovery support (Clossey et al., 2011). At a wider level, societal stigma and social exclusion of people who live with mental illness may influence implementation efforts (Piat and Lal, 2012, Chester et al., 2016).

Alongside implementation factors at multiple ecological levels of the health care system, success at supporting recovery is also influenced by the complexity of the innovation itself (Brooks et al., 2011) For example, innovation failure (Klein and Sorra, 1996) may result if recovery orientation is not well defined and understood (Piat and Lal, 2012).

2.4.1 Operationalising recovery for practice

While attempts to operationalise recovery support exist, the application of recovery to practice is inconsistent (Pilgrim and McCranie, 2013). Wittgenstein (1953) identified the

concept of "meaning is use" and argued that meanings emerge from the specific social situation in which terms are used. This has relevance to recovery, which has different meanings in use. For example, recovery is often measured in terms of reduced level of service use and lack of hospitalisation (Lloyd et al., 2008). Recovery is also increasingly used as an indicator of service quality and as a justification for cost savings (Slade et al., 2014). Key indicators such as employment, criminal justice involvement and homelessness are also used to measure recovery (Pilgrim and McCranie, 2013). Additionally, the subjective nature of personal recovery means that individual practitioners emphasise different characteristics of recovery support within their own practice. This difference in emphasis generates a "*working misunderstanding*" (p.868) (Hopper, 2007). Recovery remains a "*polyvalent*" concept (p.299) (Pilgrim, 2008) that means different things to different people, and is difficult to apply. A superficial consensus on the meaning of recovery is generated because the concept is undefined enough for multiple stakeholder perspectives to adopt the rhetoric. Available guidance on developing recovery-orientated services is diverse. The need for clarity, a consistent understanding, and operationalisation of recovery support has been identified if recovery-orientated practice is to become commonplace in mental health services (Torrey et al., 2005). To aid clarity, and to provide context to this thesis, a synthesis of existing international guidance documents was conducted to develop a conceptual framework of recovery-orientated practice (reported in Chapter 3).

To note, two approaches that promote recovery orientation are consistently reported in the literature: (1) illness self-management and (2) peer support. These are, however, considered an adjunct to services rather than a change in paradigm (Pilgrim and McCranie, 2013). Illness self-management approaches such as the Wellness Recovery Action Plan (Copeland, 1997) and the Illness Management and Recovery (IMR) program (Mueser et al., 2002) are delivered individually or in groups. The approaches introduce service users to the concept of recovery, support identification of recovery goals, and provide an information-based curriculum that:

- empowers each service user to take responsibility for his or her own life and treatment
- educates about hopefulness, quality of life, the importance of medications to symptom management, and in the case of IMR, the stress-vulnerability model
- provides a foundation for informed and shared decision making
- indicates which stakeholders will help service users to attain goals

- develops individualised plan with strategies for recognising/managing a crisis
- identifies resources for coping and builds skills to manage illness effectively (Cook et al., 2012).

Working practices which recognise the contribution of, and facilitate involvement of peer support have also been strongly advocated in promoting recovery orientation (Mead et al., 2001, Davidson and Guy, 2012, The Evidence Centre, 2015, Repper et al., 2013a). Examples include designing services that involve people living with mental illness and support them to work in partnership with practitioners to focus on their own individual goals and recovery journeys (Onken et al., 2002). Emerging evidence also suggests that mental health services provided by people with personal experience of mental illness or who believe recovery is possible are likely to promote recovery (Beresford, 2013).

2.5 Conclusion and implications for the thesis

Recovery is a complex construct with more than one meaning in use. It is open to apparent but not real consensus (a polyvalent construct) and inconsistent application (a working misunderstanding). Therefore, a knowledge gap remains on how recovery is operationalised in practice (Meehan et al., 2008). A conceptual framework addresses this need by providing a synthesised understanding of recovery-orientated practice guidance. Chapter 3 reports the development of a conceptual framework of recovery-orientated practice.

Chapter 3. A Conceptual Framework of Recovery-orientated Practice

Chapter 3 describes the development of a conceptual framework of recovery-orientated practice.

Chapter 3 comprises four sections. The rationale for developing a conceptual framework is outlined in Section 3.1, along with the background and aims. Section 3.2 describes the method used to develop the conceptual framework. Section 3.3 presents the conceptual framework of recovery-orientated practice. Finally, Section 3.4 details the link between the developed conceptual framework and the wider literature, and describes its intended use in the study.

The conceptual framework of recovery-orientated practice has been published (Le Boutillier et al., 2011), and is included in Appendix 21.

3.1 The rationale for developing a conceptual framework

Chapter 2 identified that supporting recovery in practice is complex. Although mental health services are encouraged to support recovery, there are inconsistencies in understanding and operationalisation. As described in Section 2.1, the term, "personal recovery", is commonly used to refer to the process of each individual coming to terms with, and overcoming, challenges associated with having a mental illness (Davidson et al., 2005). On the other hand, mental health practitioners lean towards a different meaning in use, making routine operationalisation (Meehan et al., 2008) and conceptualisation of recovery-orientated practice a further challenge (Jacobson and Greenley, 2001).

The implications of recovery for practice are unclear and available guidance on developing recovery-orientated services is diverse. The need for clarity, a consistent understanding, and operationalisation of recovery support has been identified if recovery-orientated practice is to become commonplace in mental health services (Torrey et al., 2005).

A conceptual framework addresses this need by providing a synthesised understanding of recovery-orientated practice guidance. A conceptual framework provides an interpretive approach to the understanding of concepts and relationships among them,

developed through iterative qualitative analysis (Jabareen, 2009) and provides an empirical basis for recovery-orientated practice and a taxonomy for recovery-orientated research.

3.1.1 Aims

The aims were (1) to synthesise the characteristics of recovery-orientated practice as stated in international guidance and (2) to develop an overarching conceptual framework which translates recovery guidance into mental health practice.

3.2 Method

3.2.1 Design

A systematised literature review was conducted (Grant and Booth, 2009) to identify recovery-orientated practice guidance. Each document was analysed using inductive thematic analysis, where analytical concepts and perspectives are derived from the data in a deliberate and systematic way (Pope et al., 2000). This approach allowed exploration of the way that each document described recovery-orientated practice, allowed unexpected themes to emerge and did not restrict the investigation to predetermined concepts or prejudge the significance of concepts (Marks and Yardley, 2004).

3.2.2 Procedures

Guidance identification

The literature search sought to identify guidance that explicitly described or developed a conceptualisation of recovery-orientated mental health practice. The term "guidance" is used to describe the range of documents included in the study, not just those that described guidelines or practice standards. A conceptualisation of recovery-orientated mental health practice was defined as: recommendations developed as a guide to mental health services and mental health practitioners on supporting the recovery of people living with mental illness, or guidance for users of mental health services to support self-advocacy of best practice and high quality service delivery. In addition, the guidance needed to be available in printed or downloadable form and written in English.

Three data sources were used to conduct the literature search. First, experts (authors of international recovery-orientated practice guidance, with clinical backgrounds in psychiatry and psychology) were asked to identify international policy and practice

guidance. Second, an internet search via Google scholar using the key terms "recovery-orientated practice" AND ("guidelines" OR "standards" OR "indicators" OR "competencies") was conducted. Third, reference lists of retrieved documents were hand-searched. An electronic database search (e.g. Medline) was not undertaken as policy and practice documents were sought rather than academic articles. The search was conducted in January 2010.

3.2.3 Analysis

The characteristics of the eligible documents were identified to describe and define the guidance. Characteristics include country, type of document and self-ascribed document classification. The author and development process (when reported) of each document was also noted, as well as the target audience.

Inductive thematic analysis (Braun and Clarke, 2006) was used to identify and synthesise the range and diversity of the key concepts of recovery-orientated practice identified in existing guidance. To meet Aim 1, data extracts from each document were selected by two analysts (the author and one analyst with a professional background in academic psychology) based on the following criteria: described characteristics of recovery-orientated practice, provided definitions of recovery-orientated practice, or offered standards or indicators of recovery-orientated practice from which a succinct summary could be extracted. The documents were re-read by both analysts to ensure an accurate level of detail was provided in the extracts so that the meanings remained in their natural context (Fossey et al., 2002).

Extracts were copied into one Microsoft Word document and an initial coding frame was developed following semantic level analysis. Three additional analysts (with professional backgrounds in academic psychology or occupational therapy) double-coded selected extracts and differences were resolved through discussion. Equal attention was paid to each data extract to identify initial codes, and individual extracts were coded under one or several themes to fully capture their meaning. Each theme was refined, and where data allowed, further sub-themes emerged.

To meet Aim 2, interpretive analysis was undertaken by two analysts (the author and one analyst with a professional background in academic psychology) to group the themes and sub-themes into practice domains. Thematic maps were used to organise the themes by clustering all codes according to connections in the data, and by considering the patterns and relationships between themes. Additional codes,

refinements to the specifics of themes, and thematic patterns continued until theoretical saturation was achieved (Braun and Clarke, 2006). A definition of each theme was formulated to describe its essence, and themes were then described and organised into a coherent detailed account with accompanying narrative. Themes were checked against each other and against the original data set in order to reflect on the description and seek all possible meanings. Multiple coding allowed the opportunity to compare interpretations of data and provided an opportunity to reflect on and enhance the awareness of the coding approach.

3.3 Results

3.3.1 Guidance identification

Thirty documents were identified, and are listed in Appendix 1. Documents came from six countries (United States of America, England, Scotland, Republic of Ireland, Denmark and New Zealand), and ranged in length from 3 to 149 pages. Their characteristics are shown in Table 3.1.

#	Reference	Country	Type of document	Self-ascribed document classification	Author	Development process	Target audience	No. of items extracted
1	Department of Health and Human Services, 2003	USA	Policy	Goals and principles	Policy makers	No details	All stakeholders	10
2	Department of Health, 1999	England	Policy	Standards	Policy makers	Consultation with reference group (consisting of service users, carers, staff, senior managers, partner agencies, advocates and clinical academics)	All stakeholders	4
3	Department of Health 2001	England	Policy	Not specified	Policy makers	No details	All stakeholders	7
4	O'Hagan, 2001	New Zealand	Policy	Competencies	Policy maker/ service user researcher	Developed by service users following literature review and consultation with service users, carers, staff and government agencies	Mental health staff	10
5	Department of Health, 2004	England	Policy	Capabilities	Policy makers	Consultation with service users, carers, managers, academics and practitioners	All stakeholders	10
6	National Institute of Mental Health England, 2004	England	Policy	Principles	Policy makers	Consultation with service users, carers and practitioners	Service users but relevant to all stakeholders	12
7	National Institute of Mental Health England, 2005	England	Policy	Principles	Policy makers	No details	All stakeholders	6
8	Department of Health, 2006	England	Policy	Recommendations	Policy makers	Literature review and consultation with reference group (consisting of service users, nurses, organisational representatives and other stakeholders)	Nurses but relevant to all stakeholders	17
9	Scottish Recovery Network & NHS Education for Scotland (2007)	Scotland	Policy	Knowledge, skills and values framework	Policy makers	Consultation with service user groups, staff and educators and literature review	Mental health staff	3
10	Mental Health Advocacy Coalition, 2008	New Zealand	Policy	Vision	Policy makers	No details	All stakeholders	15

#	Reference	Country	Type of document	Self-ascribed document classification	Author	Development process	Target audience	No. of items extracted
11	Higgins, 2008	Republic of Ireland	Policy	Criteria	Policy makers	Literature review and consultation with advocacy/voluntary organisations, independent providers, professional bodies and academic/research organisations	All stakeholders	27
12	Department of Health, 2008	England	Policy	Not specified	Policy makers	Consultation with staff, senior managers, service users, carers, and general public	All stakeholders	1
13	Sowers, 2005	USA	Research based	Indicators	Clinical academic	Literature review and consensus method with psychiatrists and advocacy groups	Psychiatrists but relevant to all stakeholders	53
14	Repper & Perkins, 2003	England	Book chapter	Components	Clinical academics	No details	Mental health staff	3
15	Davidson et al, 2009	USA	Book chapter	Standards	Clinical academic	Consultation with service users	All stakeholders	126
16	Watkins, 2007	England	Book chapter	Characteristics	Nurse	Literature review	Mental health staff	6
17	Deegan, 2007	USA	Opinion	Not specified	Service user researcher	No details	All stakeholders	8
18	Anthony, 2000	USA	Opinion	Standards	Clinical academic	Literature review and consultation with academics and researchers	All stakeholders	23
19	Roberts & Wolfson, 2004	UK	Opinion	Steps	Psychiatrists	No details	Psychiatrists but relevant to all stakeholders	21
20	Farkas et al, 2005	USA	Opinion	Standards	Clinical academics	No details	All stakeholders	16
21	Farkas et al, 2008	USA	Opinion	Implementation framework	Clinical academics	No details	All stakeholders	12
22	Spaniol, 2008	USA	Opinion	Components	Clinical academic	Draws on research, professional practice, family experience and recovery experience of service users	All stakeholders	19
23	O'Hagan, 2008	New Zealand	Opinion	Framework	Service user researcher	No details	All stakeholders	7

#	Reference	Country	Type of document	Self-ascribed document classification	Author	Development process	Target audience	No. of items extracted
24	Slade 2009a	England	Opinion	Action points	Clinical academic	No details	Mental health staff	24
25	Advocates Inc & Deegan, 2001	USA	Practice based	Standards	Service user researcher	No details	Mental health staff	13
26	Erie county office of MH/MR, Department of Human Services, 2005	USA	Practice based	Principles	Steering committee comprising service users, carers and staff	No details	All stakeholders	8
27	Cohen & Andersen, 2007	Denmark	Practice based	Goals	Service director	Consultation with service users, carers, staff, managers and external agencies	All stakeholders	12
28	Devon Partnership NHS Trust, 2008	England	Practice based	Standards	Steering group comprising service users, staff, and voluntary organisations	No details	All stakeholders	10
29	South London and Maudsley NHS Foundation Trust, 2007	England	Practice based	Vision and principles	Steering board comprising service users, carers, staff and senior managers	No details	Mental health staff	5
30	South Staffordshire and Shropshire Healthcare NHS Foundation Trust, 2008	England	Practice based	Benchmark	Service director and nurse	No details	Mental health staff	10

Table 3.1: Characteristics of recovery-orientated practice guidance (n=30)

The nature of the guidance (n=30) was diverse, with 18 documents providing guidance on developing recovery-orientated practice across all stakeholder levels (e.g. organisation and individual practice levels) and 11 at supporting recovery-orientated practice at the individual practitioner level. One document provided specific guidance for people who use mental health services to explore their role in the recovery process and to promote expectations regarding quality mental health service provision.

3.3.2 Characteristics of recovery-orientated practice (Aim 1)

Aim 1 was to synthesise the characteristics of recovery-orientated practice as stated in international guidance. A total of 498 units of text were extracted from the 30 documents. Each unit of text varied in length from one sentence to one paragraph, and described one or more components of recovery-orientated practice, resulting in 100 pages of coded data. To meet aim 1, sixteen themes were identified. These are shown in Figure 3.1.

1. *Seeing beyond "service user"*
2. *Service user rights*
3. *Social inclusion*
4. *Meaningful occupation*
5. *Recovery vision*
6. *Workplace support structures*
7. *Quality improvement*
8. *Care pathway*
9. *Workforce planning*
10. *Individuality*
11. *Informed choice*
12. *Peer support*
13. *Strengths focus*
14. *Holistic approach*
15. *Partnerships*
16. *Inspiring hope*

Figure 3.1 Characteristics of recovery-orientated practice

Sub-themes (n=31) were also identified to refine each of the sixteen themes, and to provide practice examples of operationalisation.

Aim 2 was to develop an overarching conceptual framework for translating recovery guidance into mental health practice. To meet aim 2, the themes (n=16) and 31 sub-themes were grouped into meaningful practice domains. To enhance narrative flow, Section 3.3.3 presents the conceptual framework as a whole and illustrates each practice domain, corresponding themes and sub-themes.

3.3.3 Develop a conceptual framework (Aim 2)

Four practice domains were identified: Promoting Citizenship, Organisational Commitment, Supporting Personally Defined Recovery, and Working Relationship. The practice domains and related themes are shown in Figure 3.2. The full coding framework is given in Appendix 2.

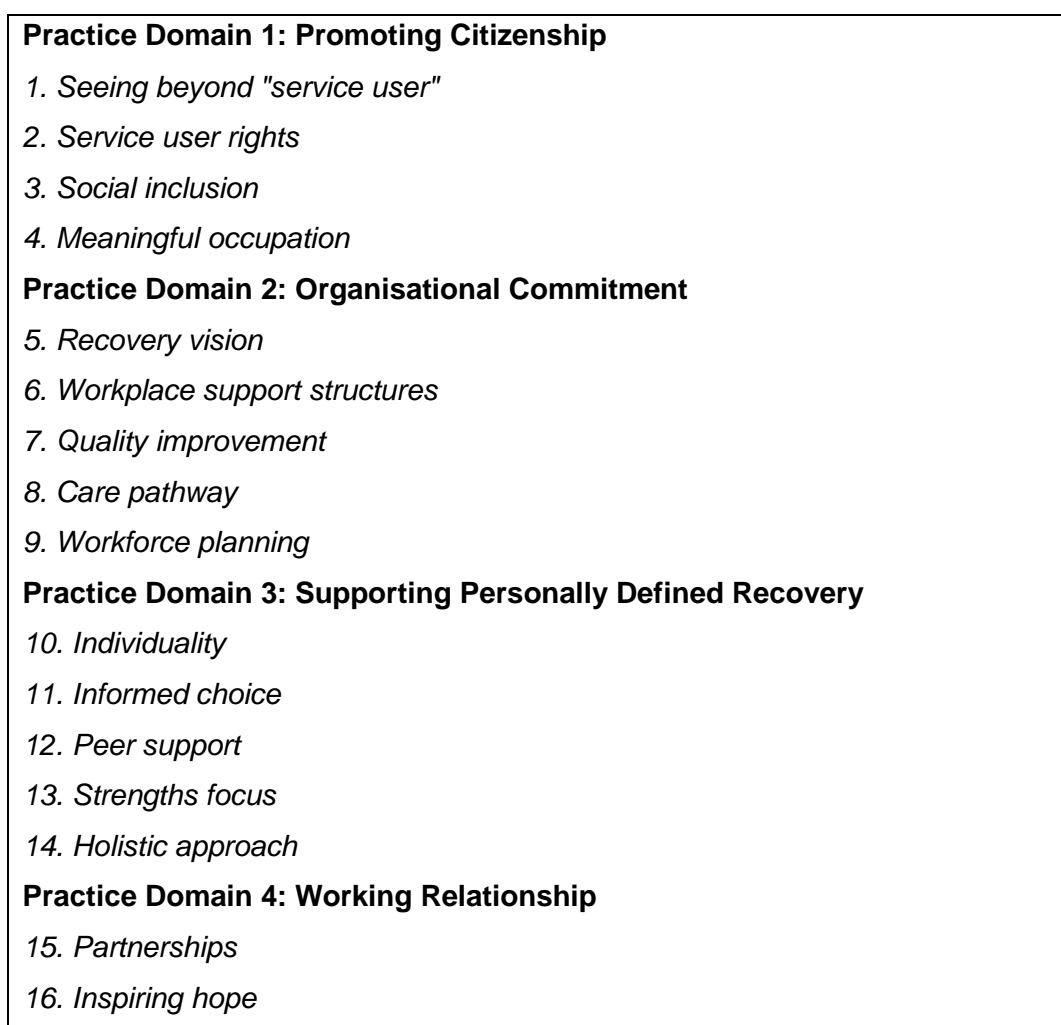


Figure 3.2: Conceptual framework practice domains and themes

Each practice domain is as important as the next, and there is no hierarchical order. Practice domain and corresponding themes will now be defined (with sub-theme

descriptions merged into each corresponding theme) to ensure a coherent and comprehensive report.

PRACTICE DOMAIN 1: PROMOTING CITIZENSHIP

The overarching practice domain called Promoting Citizenship refers to the context of mental health practice. The core aim of services is to support people who live with mental illness to reintegrate into society and to live as equal citizens. Citizenship is central to supporting recovery, where the right to a meaningful life for people living with severe and enduring mental illness is advocated. Individuals who live with mental illness are supported to claim citizenship and take their full place in society, by addressing health and social needs, basic to self respect and recovery, including an acceptable place to live, meaningful occupation, further education and training if necessary, and access to information about entitlements and benefits (South London and Maudsley NHS Foundation Trust, 2007).

Four themes are grouped in this practice domain: Seeing beyond "service user", service user rights, social inclusion and meaningful occupation. Figure 3.3 illustrates the Promoting Citizenship practice domain with related themes and sub-themes.

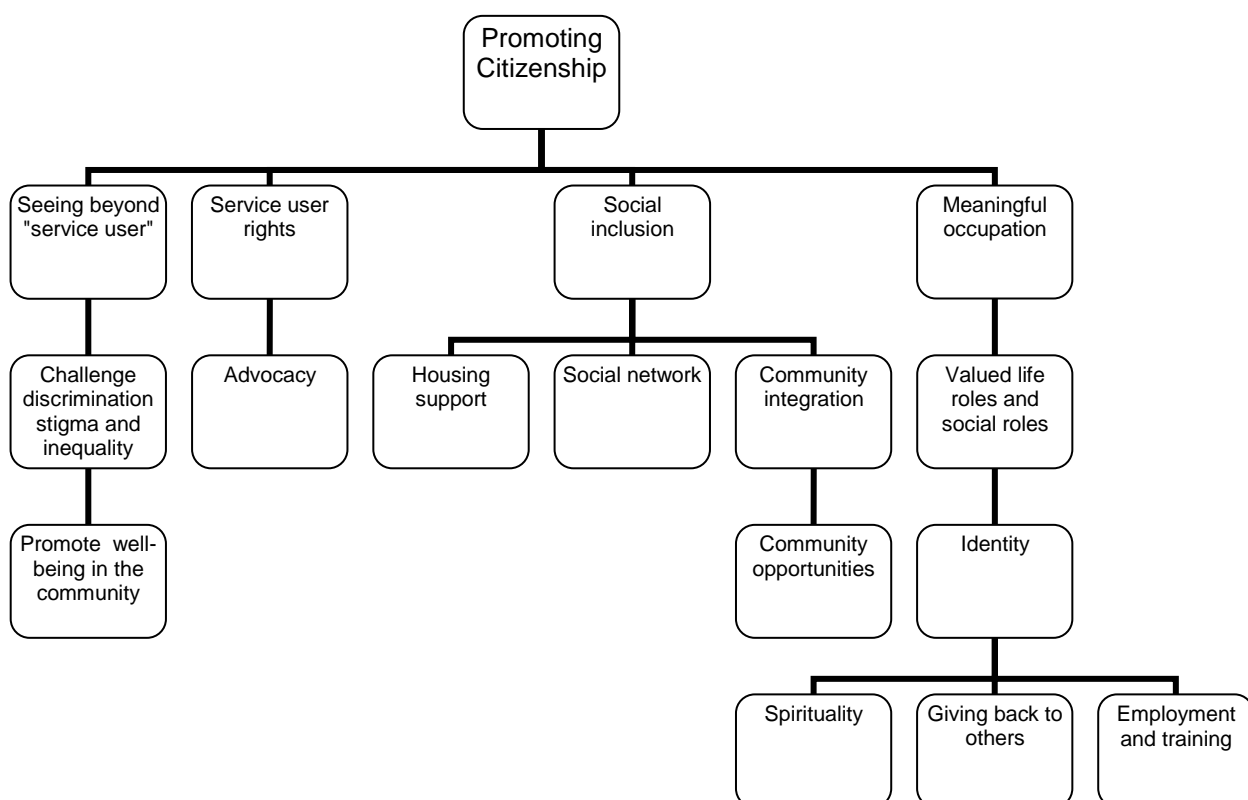


Figure 3.3: Practice Domain 1 - Promoting Citizenship

Theme 1: Seeing beyond "service user"

A greater emphasis on seeing beyond the "service user" is specified, where individuals who access mental health services are people first, and are not defined by their service use or diagnosis. Alongside, societal stigma and discrimination are also challenged. Practitioners are encouraged to recognise instances of discrimination both in services and in the community, and to correct discriminatory stereotypes. Staff are expected to educate friends, family and community members about living with a psychiatric disability through example and by correcting stigmatizing stereotypes (Advocates Inc and Deegan, 2001). Services support anti-stigma campaigns to educate the general public and support the reduction of societal discrimination associated with mental illness by increasing awareness that people can and do recover from mental illness.

'[Staff] fight stigma at a local level by linking with schools, colleges and employers, share working space with non-mental health organisations, open days at inpatient units, invite local media, form links with voluntary groups' p.37 (Department of Health, 2006).

One strategy for challenging discrimination, stigma and inequality is to promote mental well-being in the community (Department of Health, 1999). Recovery-orientated services have a responsibility to promote mental health awareness and recovery in the wider community to improve the mental wellbeing of the general public.

Theme 2: Service user rights

Practitioners have an awareness of human rights issues and ensure the rights and interests of individuals accessing mental health services and of families and carers are respected.

'A competent mental health worker understands and actively protects service users' rights. They demonstrate knowledge of human rights principles and issues... they demonstrate knowledge of service users' rights within mental health services and elsewhere... they demonstrate the ability to promote and fulfil service users' rights' p.16-17 (O'Hagan, 2001).

Service users' rights to disagree with professional judgements are also respected.

'Staff appreciate the fact that based on a complex interaction of the person's conditions and his or her past experiences in the behavioural health care system, people with behavioural health disorders may be reluctant to assume some of the rights and responsibilities promoted in recovery-oriented systems. They may initially express reluctance, fears, mistrust, and even disinterest when afforded the right to take control of their treatment and life decisions. Exploring

and addressing the many factors influencing such responses is an important component of care.' p.143 (Davidson et al., 2009b).

Service users have access to advocacy services at any stage of their recovery journey. If mental health services are unable to provide advocacy support, referral is made to external advocacy services. There is a specific need for advocacy if experiencing involuntary treatment (Sowers, 2005).

Theme 3: Social inclusion

Practitioners work closely with organisations and personal social networks to promote opportunities for community integration outside the mental health service, to improve the quality of participation in community life.

'All services demonstrate socially inclusive practice which is supportive of people living ordinary lives in ordinary settings and considers, in particular, peoples' needs for accommodation, occupation, education, personal relationships, money and participation in community life' p.4
(Devon Partnership NHS Trust, 2008).

Practitioners liaise with local housing authorities to ensure appropriate and affordable housing that meets service users' needs is provided, and those who are able to do so, live independently in regular housing of their choice. Service users living in supportive housing are provided with accommodation that is as least restrictive as possible and that does not compromise dignity and privacy.

Practitioners value the importance of relationships and assist people to connect with others. People are enabled to develop a social network that provides the variety of support needed in their recovery, and might include relationships with family, friends, peers, community members and staff. Recovery-orientated services support family and friends in maintaining their relationship with their relative/friend who lives with mental illness.

Recovery-orientated services work closely with mainstream organisations to promote opportunities for community integration for service users. Practitioners develop community resource inventories, build their knowledge of local community organisations and support service users to use them (South London and Maudsley NHS Foundation Trust, 2007).

Theme 4: Meaningful occupation

Service users are supported to participate in meaningful occupations and to identify a purposeful lifestyle within and beyond the limits of mental illness. An assessment of occupational status is completed and practitioners support people to participate in purposeful occupations and their chosen activities of everyday life (Roberts and Wolfson, 2004). Service users are encouraged to develop habits and routines in everyday living, leisure, and vocational activities.

'[Staff] need to have the skill of facilitating decision making about which valued role that person wants' p.26 (Farkas et al., 2008).

Recovery-orientated services see people in roles other than "service user". This may involve having a culture that acknowledges important events such as birthdays, graduations, bereavements in the lives of service users and staff (Davidson et al., 2009b). Spirituality is addressed and service users are actively supported to maintain their chosen identity. Opportunities are provided for service users to contribute to society and to give back to others. Practitioners provide access to education and employment opportunities for those choosing to engage in such activities. Individualised placement and support is identified as the predominant approach to supporting people into work (Sowers, 2005).

PRACTICE DOMAIN 2: ORGANISATIONAL COMMITMENT

The practice domain called Organisational Commitment refers to the organisational context in which services are provided and identifies that service structures and systems support recovery. Organisations that support recovery orientation demonstrate a commitment to ensure the work environment and service structure is conducive to promoting recovery-orientated practice. The organisational culture gives primacy to recovery, and focuses on and adapts to the needs of people rather than those of services. Five themes, recovery vision, workplace support structures, quality improvement, care pathway, and workforce planning, are grouped in this practice domain. Figure 3.4 illustrates the Organisational Commitment practice domain with related themes and sub-themes.

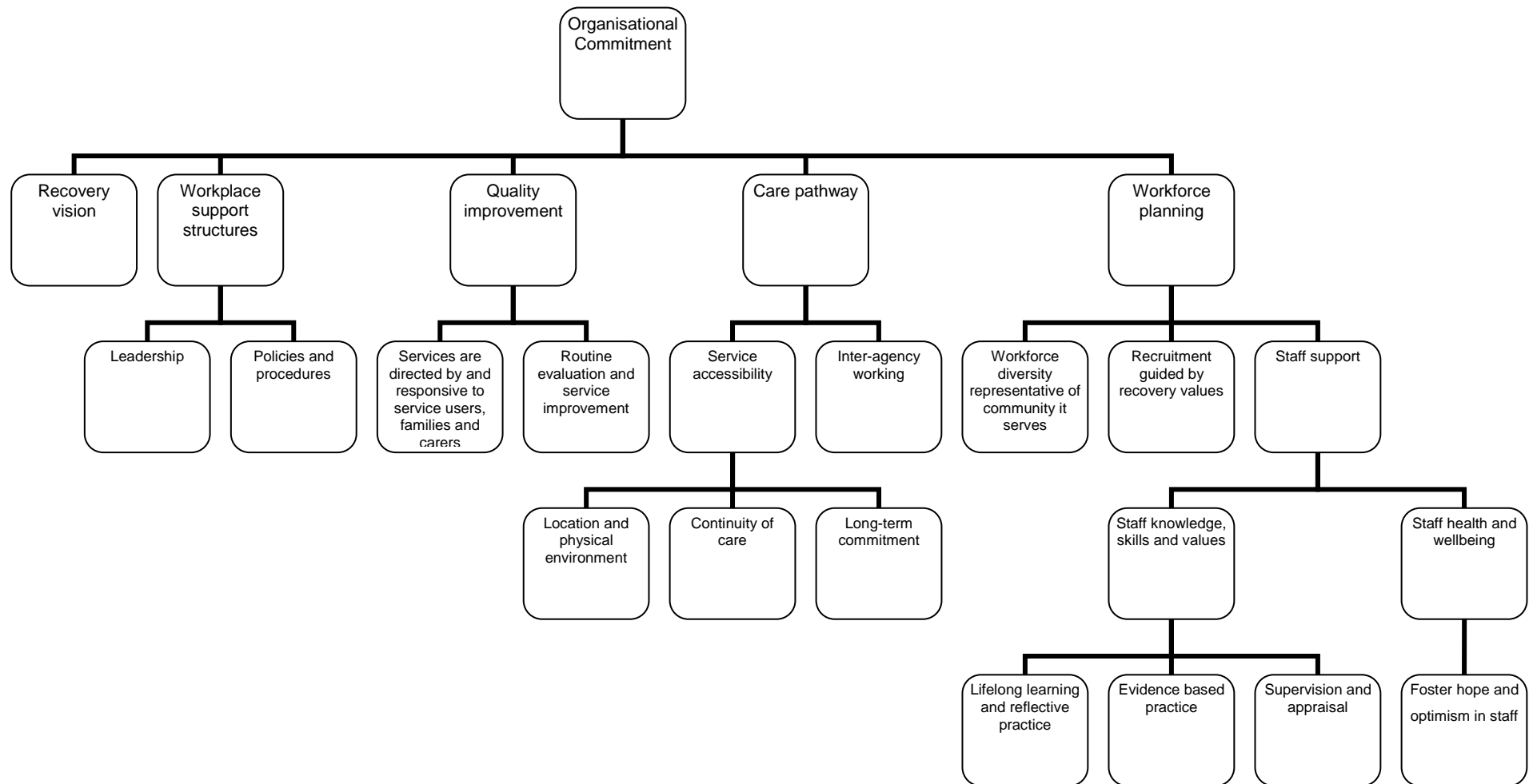


Figure 3.4: Practice Domain 2 - Organisational Commitment

Theme 5: Recovery vision

Recovery is the focus of services and there is a commitment to practice change for services that have yet to adopt a recovery approach. Recovery is viewed as the overarching vision of services, and mission and vision statements articulate an organisational commitment to recovery values and practices. Principles, values and attitudes consistent with recovery are established as unifying concepts of service provision with a focus shift from preventing relapse to promoting recovery and self-determination as the foundation of service delivery. Practice that does not support recovery is addressed.

'Each team takes responsibility to ensure that the ethos and practices within the team is consistent with the principles of a recovery approach. Each individual within the service reflects on their practice on an ongoing basis to identify attitudes or behaviours that may be incongruent with the principles of a recovery approach' p.15 (Higgins, 2008).

Theme 6: Workplace support structures

Recovery principles are embedded into existing workplace support structures, and practitioners have permission to support recovery values. Financial structures and contracting arrangements support and encourage recovery-orientated service development. Commissioning structures support recovery-orientated outcome indicators and local team budgets are allocated according to recovery-orientated practice requirements.

'Creative contracting and financing mechanisms support evidence-based practices and recovery-based services' p.3 (Deegan, 2007).

Leadership that reinforces the recovery vision is required. Recovery champions are present in teams who focus on promoting recovery-orientated services. The agreement to embed recovery principles is reflected in policies and procedure documents.

'Recovery oriented service design will be reflected in policy and procedure documents, including financial structures that encourage such service development' p.764 (Sowers, 2005).

Theme 7: Quality improvement

Central to quality improvement is the ability of mental health practitioners to encourage service user participation in service development and evaluation. Individuals living with mental illness, their families and carers, and practitioners are encouraged to make

meaningful contributions to the design, delivery and monitoring of mental health service provision. Services therefore focus on people's right to full partnership in all aspects of their recovery, including involvement in decisions on designing, planning, delivering and evaluating the service that supports their recovery. Service users are also encouraged to participate in research, staff training, and recruitment. Recovery-orientated services widen management structures to incorporate the expert knowledge of service users as equal partners with professionals (Sowers, 2005).

Recovery-orientated services undergo regular systematic evaluations by a range of stakeholders including service users, family members, carers and staff. Service outcome indicators reflect the fact that the desired goal of recovery-orientated care is to promote growth, independence, and wellness. This means that service user goals and service outcomes might sometimes involve the taking of reasonable risks that can result in interim setbacks. This is seen as productive to recovery and not detrimental to service evaluation.

Theme 8: Care pathway

Recovery-orientated services accept non-linear continuums of care, and services are designed to allow people to move in and out of the system as required. There is a low threshold for entry into services, and services do not exclude people from care based on symptoms, substance use or unwillingness to participate in service provision options. Recovery-orientated services are encouraged to operate outside of usual working hours to allow for people to work and to support activity in the evenings and at weekends. Access to service environments is by service user preference and not practitioner or service preference.

'The user of services decides if and when to begin the recovery process and directs it; therefore, service user direction is essential throughout the process'
p.4 (National Institute of Mental Health England, 2004).

The physical environment of services is welcoming and staff values and attitudes that imply a "them and us" environment are challenged. A wide range of service provision is available from a range of different points within the service or from outside agencies to ensure comprehensive and co-ordinated provision. One particular example is coordinated care in times of crisis. For example, rapid access to help in a crisis when required, but once the crisis is resolved not to encourage service users to get caught up in long-term involvement and monitoring (Roberts and Wolfson, 2004). Roberts &

Wolfson (2004) also suggest that service users are allowed '*...to renew contact with their service as soon as problems arise, without having to wait for complex referral processes to be instigated.*' p. 43.

Services should not remain central to a person's life over time, and discharge criteria for each person from services are clearly defined. Discharge planning starts when the person enters the service. Recovery-orientated services are available for as long or as short a period as required by each individual. Service users are able to renew contact with services as soon as they require it, and do not have to wait for complex referral processes to be completed. Services are joined up to ensure continuity of care across services and practitioners.

'The full range of comprehensive services and supports an individual needs to recover are accessible, flexible, individualised, and coordinated...and provided for as long as the individual wants them' p.3 (Deegan, 2007).

Theme 9: Workforce planning

There is a commitment to recruit a diverse range of people including those with lived experience of severe and enduring mental illness, and those from ethnic minority backgrounds. Employing people with first hand experiences of recovery as peer workers at crisis entry points is recognised as particularly beneficial (Scottish Recovery Network and NHS Education for Scotland, 2007, Higgins, 2008). Recruitment is guided by recovery values and staff are recruited based on their knowledge, attitudes and skills in recovery.

'Staff can support recovery by...recruiting people with recovery competencies, by interviewing with questions such as "Why do you suppose people with mental illness want to work?" to give a chance for applicants to demonstrate their values, assessing whether key knowledge, attitudes and skills about recovery are present' p.11 (Slade, 2009a).

Recovery-orientated services are responsible for ensuring that service users are always met by competent employees. Staff understand the principles, processes and environments that support recovery and apply this knowledge to their work. Recovery-orientated services ensure that staff training and development is prioritised as an essential function to increase individual practitioners' competencies in recovery-orientated practice, and to provide opportunities for staff growth, independence and wellness. Staff are encouraged to complete a personal recovery and wellness action plan, to promote experiential learning (Davidson et al., 2009b).

Recovery-orientated services make available regular formal and informal professional supervision and support to staff. All practitioners, teams and services are subject to regular performance review to ensure that staff are safe, appropriately qualified and equipped to deliver recovery-orientated practice. Personal development is a component of supervision and staff are encouraged to reflect and keep up to date with changes in practice. Staff counselling services are available and staff identify individual self-care strategies (Higgins, 2008). Recovery-orientated services foster hope and optimism in staff.

PRACTICE DOMAIN 3. SUPPORTING PERSONALLY DEFINED RECOVERY

The practice domain called Supporting Personally Defined Recovery refers to the practice context and identifies that practitioners view recovery at the heart of practice, and not as an additional task. Service users are supported to define their own needs, goals, dreams, and plans for the future to shape the content of care. Five themes were identified: individuality, informed choice, peer support, strengths approach, and holistic approach are grouped in this practice domain. Figure 3.5 illustrates the Supporting Personally Defined Recovery practice domain with related themes and sub-themes.

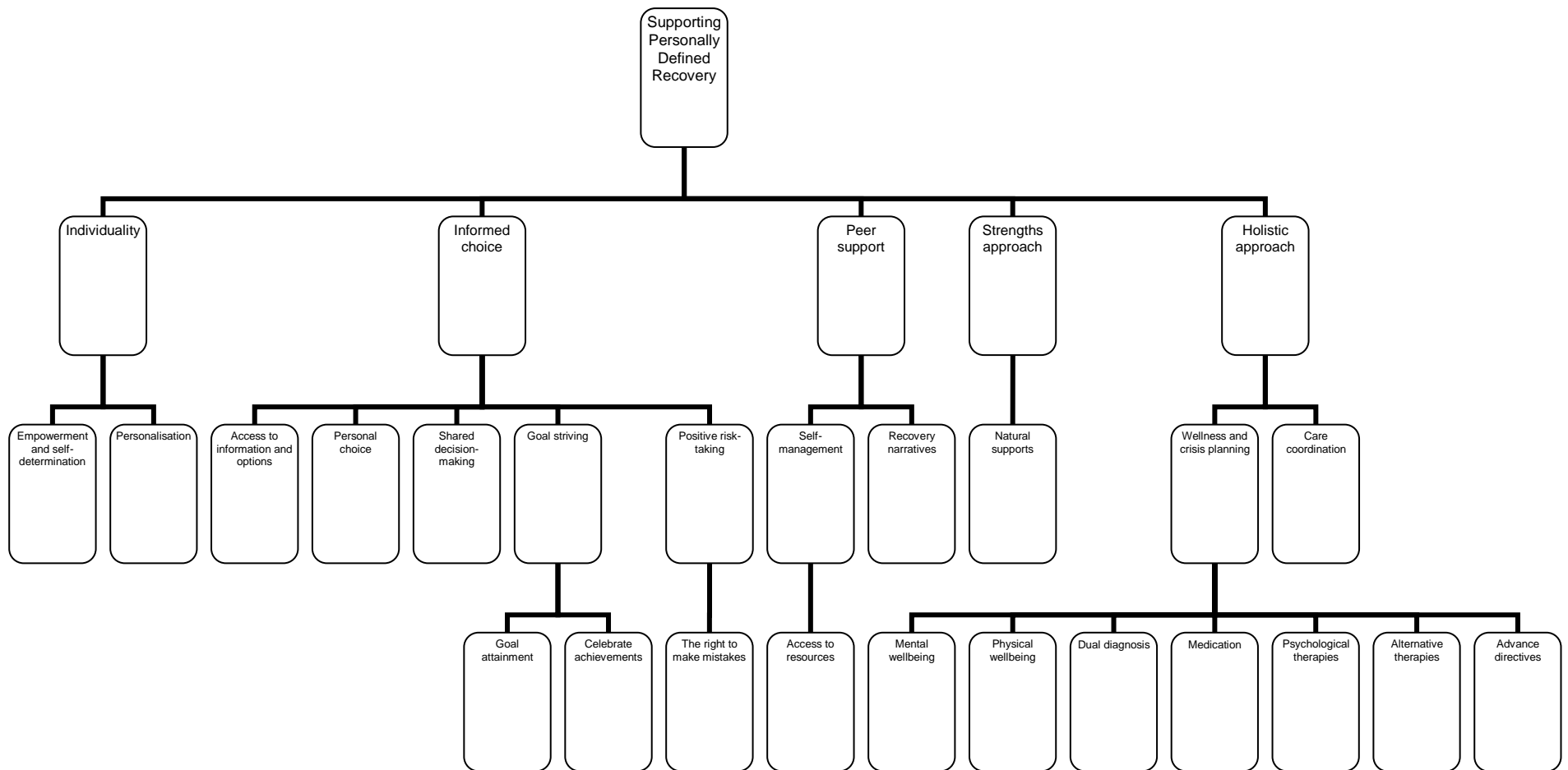


Figure 3.5: Practice Domain 3 - Supporting Personally Defined Recovery

Theme 10: Individuality

Service user individuality is promoted and autonomy is supported. Practitioners promote individual preference, self-determination over life, the dignity of risk, and the right to failure. Professional expertise is used to support service user self-determination and empowerment. Personalisation and individualised budgets are promoted and enhance service user choice (Davidson et al., 2009b). Recovery-orientated services are encouraged to use the core principles of person-centred planning to build individualised recovery plans (Slade, 2009a).

'The care provider, in full partnership with consumers and families, will develop an individualised plan of care' p.6 (Department of Health and Human Services, 2003).

Theme 11: Informed choice

Staff have the ability to facilitate service users to make informed choices for recovery, and processes are in place to discuss the pros and cons of available care options.

'The service focuses on people's right to make individual decisions or choices about all aspects of their own recovery process, including areas such as the desired goals and outcomes, preferred services used to achieve the outcomes, preferred moments to engage or disengage in services' p.145 (Farkas et al., 2005).

Individuals have access to timely and accurate information that provides options and supports personal choice and decision-making. Service users have the right to share in decision making and to be involved in all decisions that affect their lives. Staff are skilled in facilitating decision making. This might also involve encouraging service users to write their own account and treatment preferences in patient records (Roberts and Wolfson, 2004). Training initiatives support service users to develop their own capacity to self-direct their care and life decisions.

'Care and treatment decisions are arrived at through meaningful negotiation and collaborative discussion between service users and staff.' p.17 (Higgins, 2008).

Recovery-orientated practitioners support service users to identify goals based on their unique interests, values, needs and preferences. Goals might include functioning in living, learning, working and/or social environments. Service users are supported to prioritise goals.

'Individuals are not required to attain, or maintain clinical stability or abstinence before they are supported by the planning team in pursuing such goals as employment.' p.98 (Davidson et al., 2009b).

Care planning is related to the attainment of these stated goals and not solely to commonly desired clinical outcomes. The responsibilities of the people who will provide any help that is needed to achieve the goals are clarified, and planning focuses on the identification of concrete next steps along with specific timelines to allow service users to move toward their vision for the future. Recovery-orientated services celebrate success and goal attainment.

Recovery-orientated practitioners promote safety, positive risk taking, and risk self-management and service users are allowed to take responsibility for their own actions. Services recognise that it is a service user's right to take informed risks that risk avoidance is harmful, and that risk is essential for growth and recovery. Staff work with risk and shift from risk avoidance to risk-sharing. Each service user decides on the level of risk they are prepared to take with their health and safety. Defensible decision making in relation to risk is fostered and risk management systems are developed which recognise the tension between types of risk which are to be avoided and types of risk which are essential for growth and recovery. Mistakes are valued as an opportunity for people to learn.

'Staff work creatively with the tensions created between promoting safety and empowering the service user to take therapeutic and positive risks' p.16 (Higgins, 2008).

Theme 12: Peer support

Recovery-orientated services incorporate peer supports as an integral part of care. Practitioners foster the development of and promote access to peer support facilities and exposure to people in recovery who can model empowerment and demonstrate experience in self-managing. Staff collaborate with service users and voluntary sector agencies to build capacity where peer support programmes are not available. Staff support service users to access resources, develop their own solutions, coping strategies, practical and social skills to manage their illness and everyday life. Self-help approaches allow service users to retain the greatest possible control over their own lives and reduces the need for service users to rely on professional support. All service users are supported to develop skills and strategies to achieve and maintain wellbeing and develop resilience to stressful life experiences.

'Staff work with service users to ensure that they have the educational preparation needed to access and use peer supports and self-help materials. User friendly guides on user-led peer supports and self-help material are available to service users' p.18 (Higgins, 2008).

Practitioners demonstrate knowledge of and empathy with service user recovery narratives, and stories of recovery are displayed on the walls of service environments. Service users are supported to share their own recovery stories. Professional story tellers, speakers bureaus and media opportunities are suggested as possible avenues (Slade, 2009a).

Theme 13: Strengths focus

The strengths of individuals who access mental health services are acknowledged and encouraged. Capabilities as well as needs are discussed, and a strengths model is the central focus of each assessment and care plan.

'In addition to the assessment of individual capacities, it is beneficial to explore other areas not traditionally considered 'strengths' - for example, the individual's most significant or most valued accomplishments, ways of relaxing and having fun, ways of calming down when upset... educational achievements, personal heroes... and so forth' p.108 (Davidson et al., 2009b).

Service users, families and carers are encouraged to use the natural supports in the community, and the value of existing relationships and connections in the community are also acknowledged by practitioners.

'While strengths of the individual are a focus of the assessment, thoughtful consideration also is given to potential strengths and resources within the individual's family, natural support network, service system, and community at large.' p.107 (Davidson et al., 2009b).

Theme 14: Holistic approach

Recovery-orientated services offer a holistic approach which includes a range of options to meet medical, physical, social, occupational, psychological, emotional, spiritual, and religious needs. Practitioners offer both day-to-day and crisis support and staff are able to support service users to deal constructively with trauma. Recovery-orientated practitioners encourage service users to write their own crisis and contingency plans and support service users to develop a recovery management or wellness recovery action plan (Davidson et al., 2009b). This plan focuses on wellness, the treatments and supports that will facilitate recovery and the resources that will

support the recovery process. The plan identifies a wide range of both professional supports and alternative strategies to support the person's recovery particularly those which have been helpful to others with similar struggles. Recovery-orientated services have an established process for obtaining informed advance directives from service users.

'Illness self-management strategies and daily wellness approaches such as WRAP are respected as highly effective, person-directed, recovery tools, and are fully explored in the assessment process' p.108 (Davidson et al., 2009b).

PRACTICE DOMAIN 4. WORKING RELATIONSHIP

The practice domain called Working Relationship refers to the interpersonal context of recovery and the relationships that are developed with people who use services. Practitioner interactions demonstrate a genuine desire to support individuals who live with mental illness and their families to fulfil their potential and to shape their own future. A therapeutic relationship is essential in supporting recovery where partnership working and hope are promoted. Two themes, partnerships and inspiring hope, are grouped in this practice domain. Figure 3.6 illustrates the Working Relationship practice domain with related themes and sub-themes.

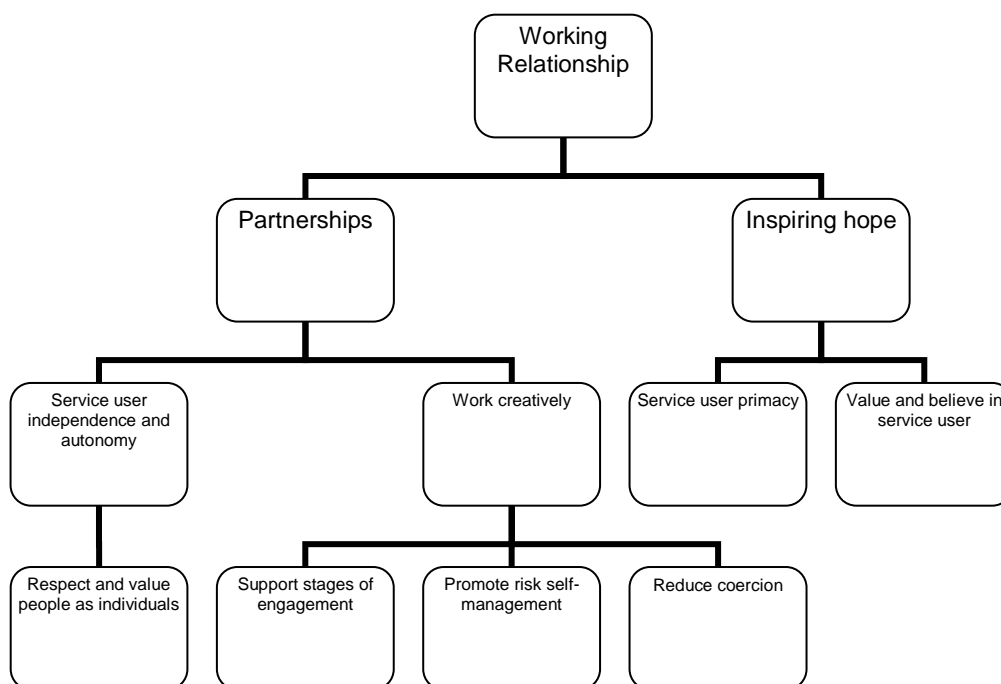


Figure 3.6: Practice Domain 4 - Working Relationship

Theme 15: Partnerships

Recovery-orientated practitioners actively partner with service users in all aspects of care. Recovery-orientated services recognise the power shift in relationships between staff and service users. Relationships are respectful and empathetic, and staff demonstrate self-awareness of their own life experiences and use this to manage relationships that facilitate recovery. This partnership relationship is sometimes described as mutuality, the view that staff have also recovered from challenges and that it can be helpful to share this commonality (Spaniol, 2008).

Professional roles are collaborative rather than authoritative and transform to that of coach. Staff use listening and facilitating skills rather than prescribing or directing. Professional knowledge is not devalued, the coaching role promotes the person's needs, provides choices, and educates the person about the pros and cons of each intervention and provides choices, also called a recovery guide approach (Davidson et al., 2009b). Staff are aware of the power differences within the relationship and continually work to ensure that the voice of the consumer is heard. Staff communicate respectfully and avoid language that uses labels and provides minimal information regarding a person's individuality and humanity. The language used in services reflects this change.

'Staff are mindful of the power of language and carefully avoid the subtle messages that professional language has historically conveyed to people with mental illness and their loved ones' p.109 (Davidson et al., 2009b).

Theme 16: Inspiring hope

Individuals who access mental health services are valued as experts in their own experience. Practitioners value and believe in service users' abilities and foster hope and optimism in their work.

'The system is grounded in a belief that recovery is possible and is expected outcome of treatment' p.3 (Deegan, 2007).

Recovery-orientated practitioners believe in service users' abilities and service users are empowered to take control of their care and recovery. Staff believe that service users can shape their own future.

'The service focuses on the inherent capacity of any individual to recover, regardless of whether, at the moment he or she is overwhelmed by the

disability, struggling, living with or living beyond the disability' p.145
(Farkas et al., 2005).

Distribution of themes across documents

The grouping and distribution of themes across documents (n=30) is shown in Table 3.2.

Guidance	PROMOTING CITIZENSHIP				ORGANISATIONAL COMMITMENT					SUPPORTING PERSONALLY DEFINED RECOVERY					WORKING RELATIONSHIP	
	Seeing beyond service user	Service user rights	Social inclusion	Meaningful occupation	Recovery vision	Workplace support structures	Quality improvement	Care pathway	Workforce planning	Individuality	Informed choice	Peer support	Strengths focus	Holistic approach	Partnerships	Inspiring hope
1						X	X	X	X	X	X			X	X	
2	X														X	
3	X	X	X	X	X			X	X		X					
4	X	X	X		X		X		X	X	X	X		X	X	X
5	X	X		X			X	X	X		X		X	X	X	X
6			X	X	X			X		X	X		X	X	X	X
7	X				X					X			X			
8	X		X	X		X	X		X	X	X			X	X	X
9	X	X	X	X			X		X	X	X	X	X	X		X
10	X	X	X	X	X	X	X		X	X		X		X	X	

Guidance	PROMOTING CITIZENSHIP				ORGANISATIONAL COMMITMENT					SUPPORTING PERSONALLY DEFINED RECOVERY					WORKING RELATIONSHIP	
	Seeing beyond service user	Service user rights	Social inclusion	Meaningful occupation	Recovery vision	Workplace support structures	Quality improvement	Care pathway	Workforce planning	Individuality	Informed choice	Peer support	Strengths focus	Holistic approach	Partnerships	Inspiring hope
11	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X
12		X							X						X	
13		X	X	X	X	X	X	X	X	X	X	X		X	X	
14			X													X
15	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
16		X			X		X			X	X		X	X	X	X
17			X	X	X	X	X		X		X	X		X		X
18		X	X		X	X	X	X	X	X	X	X		X		
19				X	X		X	X		X	X		X	X	X	X
20			X		X	X	X	X	X	X	X		X	X	X	X
21			X	X	X	X	X		X	X	X	X	X		X	X

Guidance	PROMOTING CITIZENSHIP				ORGANISATIONAL COMMITMENT					SUPPORTING PERSONALLY DEFINED RECOVERY					WORKING RELATIONSHIP	
	Seeing beyond service user	Service user rights	Social inclusion	Meaningful occupation	Recovery vision	Workplace support structures	Quality improvement	Care pathway	Workforce planning	Individuality	Informed choice	Peer support	Strengths focus	Holistic approach	Partnerships	Inspiring hope
22		X	X	X	X		X	X	X	X	X	X		X	X	X
23	X	X	X	X		X	X			X	X	X		X	X	X
24	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
25	X		X						X	X	X					X
26			X		X		X	X		X			X	X	X	
27			X	X			X		X	X	X				X	X
28	X		X				X	X	X		X			X		
29	X	X	X	X		X			X	X	X	X		X	X	X
30	X		X	X						X	X					X
Total	16	15	23	18	17	13	21	13	21	23	24	13	12	21	21	20

Table 3.2: Distribution of conceptual framework themes (n=16) across included documents (n=30)

The conceptual framework themes (n=16) are represented across the included documents (n=30). Informed choice was the most prominent theme, appearing in the extracted data of 24 out of the 30 documents.

3.4 Discussion

This chapter presents two key findings: the characteristics of recovery-orientated practice guidance based on current international perspectives, and an overarching conceptual framework of recovery-orientated practice that can be used to aid the translation of recovery guidance into clinical practice. The conceptual framework was developed using inductive thematic analysis which identified four practice domains: Promoting Citizenship; Organisational Commitment; Supporting Personally Defined Recovery; and Working Relationship.

3.4.1 Implications for policy and practice

The emerging conceptual framework of recovery-orientated practice is wide-ranging, encompassing the need to carefully consider both the support offered by services and the nature of the relationship between services and service users. It also identifies the need for consistency and commitment from the wider organisation as well as the importance of supporting people to access the normal entitlements of citizenship outside of mental health settings. The need for recovery-orientated practice to be promoted across health system levels is evident: at a societal level (promoting citizenship), an organisational level (organisational commitment) and an individual level (supporting personally defined recovery and working relationship).

While socio-political involvement and responsibilities may be outside the usual sphere of practice for mental health services, Davidson and colleagues (2010) argue for a conceptual framework that supports the fundamental role of independence and self-determination in enabling people who live with mental illness to exercise their rights of citizenship and to live meaningful lives (Davidson et al., 2010). It can be a challenging view that promoting citizenship may be the job of the mental health system (Tew et al., 2012), leading to the suggestion that *'becoming social activists who challenge stigma and discrimination, and promote societal well-being may need to become the norm rather than the exception for mental health professionals in the 21st Century'* p.2 (Slade, 2010).

The involvement of organisations is also highlighted (Sainsbury Centre for Mental Health, 2009), pointing to the need to develop a whole-systems approach. To operate within a recovery-orientated practice framework, organisations need to provide an

infrastructure for service delivery and quality assurance that promotes a recovery vision to both the workforce and those accessing mental health services.

The process of supporting personally defined recovery reflects the complexity and dimensions of practice across both evidence based practice and illness experience (Davidson et al., 2009a). The focus on individuality and holism is enhanced by the working relationship where the value of therapeutic alliance that promotes hope-inspiring partnerships is identified (Moran et al., 2014, Kirkpatrick et al., 1995). Informed choice is a basic element of good practice and was the most prominent theme across recovery-orientated practice guidance documents. There is a risk that this basic element of good practice is translated to the rhetoric of 'we support recovery already'.

There is a policy expectation that practitioners embed a recovery framework into their existing perspectives of disability and health (Torrey et al., 2005, Shepherd et al., 2008). The conceptual framework can be used to address this need. One example is viewing recovery-orientated practice within an ecological theoretical framework (World Health Organization, 2001), where the life context, the environment and the relationship between each individual and their environment are considered (Deegan, 1996, Davidson et al., 2009b). The four practice domains can be mapped on to the ecological theoretical framework where awareness of the socio-political environment (promoting citizenship), workplace environment (organisational commitment), practice approach (supporting personally defined recovery) and the practice-environment interaction (working relationship) can be considered. The conceptual framework promotes awareness of the impact of ecological factors such as health care systems, societal, and life context influences on recovery (Onken et al., 2007).

The conceptual framework can be used to aid the understanding and translation of recovery-orientated practice guidance into practice and while the understanding of recovery-orientated practice is still developing, practices that are reflective of the four practice domains should be promoted ((Mueser et al., 2002, Davidson et al., 2010).

3.4.2 Strengths and limitations

The study considered a broad range of documents to explore the breadth of recovery-orientated practice, and whilst the sample size was influenced by what was considered feasible for a qualitative analysis, it is substantially larger than is usual for a study of this type. Robust qualitative methodology was used to maximise the quality of the synthesis. The main limitation is the non-systematic approach to identifying the

guidance documents. The approach could not meet the same standards as a systematic review due to the difficulty in applying systematic review methods outside of academic literature searching. The rationale for analysing widely-used documents is that recovery orientation is a developing area of research and practice, and its evolving meaning is both represented and influenced by prominent policy and practice documents. The literature search was a systematised review (includes elements of systematic review process but may not include comprehensive searching or quality assessment) rather than a systematic review (Grant and Booth, 2009). Therefore not all existing guidance documents were identified in the search, leading to reduced coverage of important guidance, for example, from Canada (Mental Health Commission of Canada, 2009), and Australia (Australian Health Ministers, 2009). Informal analysis indicates these documents are consistent with the findings presented here, but the conceptual framework should be considered a heuristic to be further developed and refined. The inclusion of guidance only available in English is a further limitation.

While the conceptual framework provides a conceptual overview built from robust analysis, it is one representation and is not a definitive guide. In other words, a conceptual framework is a "*plane of reality*" (p.49) (Jabareen, 2009). Although evidence-based approaches and interventions (e.g. Wellness Recovery Action Planning) are promoted in the guidance, few guidance documents provide examples of operationalisation. For example, although education is implied, the guidance does not provide a clear anti-stigma mechanism or acknowledge the lack of existing interventions to address stigma. Further research to operationalise the practice domains into working practices is required to enhance utility for mental health services and practitioners. The complexity of translating recovery into practice also dictates the need for context specific guidance. Another reason for considering the conceptual framework as a heuristic is because it is developed from practice guidance documents that are socially-constructed and that may not reflect recovery-orientated practice in reality.

A key challenge for mental health services is the lack of clarity around what constitutes recovery-orientated practice. The synthesis of guidance contributes to the understanding of recovery-orientation, and the resulting conceptual framework can be used to aid the translation of recovery-orientated guidance into practice.

3.4.3 Conclusion and implications for the thesis

The aim of this chapter was to contribute to the understanding of the characteristics of recovery-orientated practice identified in definitions and descriptions of existing international guidelines, and to present the procedures of development, and resulting conceptual framework of recovery-orientated practice.

As reported in Chapter 2, the diversity of guidance highlights the complexity of translating recovery into practice. A translational gap between knowledge and routine implementation in mental health practice has also been cited as a major challenge to innovation in mental health (Fixsen et al., 2005, Tansella and Thornicroft, 2009). Research to apply the conceptual framework of recovery-orientated practice in practice, alongside research to address the translational gap to enhance implementation efforts (Whitley et al., 2009) will begin to bridge this gap.

The thesis will now address the translational gap by considering factors associated with providing routine recovery-orientated practice. Chapter 4 presents the grounded theory methodology and qualitative methods used to explore staff perspectives on supporting recovery to better understand the determinants of incorporating recovery support into routine front-line practice. The findings are reported in Chapter 5.

Chapter 4. Grounded Theory Methodology and Methods

The aim of developing a grounded theory was to help understand staff perspectives on recovery-orientated practice, and to identify factors that help or hinder staff (clinician and manager) efforts to provide recovery support. Chapter 4 presents both the grounded theory methodology and the qualitative methods used to explore staff perspectives on supporting recovery. The methodology and methods are reported together because describing the grounded theory methodology enables the reader to contextualise the methods and procedures, and outlining the chosen methods demonstrates how grounded theory methodology was applied. The consolidated criteria for reporting qualitative research (COREQ) guideline was used to ensure quality when reporting the research in this chapter. The COREQ is a 32 item quality checklist developed for use when reporting qualitative studies using interviews and focus groups (Tong et al., 2007). Thirty one of the 32 items are reported, listed in Appendix 3.

Chapter 4 comprises four sections. The study aims are outlined in Section 4.1, along with the rationale for developing a grounded theory. Section 4.2 provides a brief overview of the development of grounded theory, and outlines theoretical orientations of the methodology. Sampling and data collection strategies specific to grounded theory are then discussed in Section 4.3, as well as the use of these strategies in the study. Finally, Section 4.4 provides a full description of the coding strategies including theoretical sensitivity.

The results of the grounded theory study are presented and discussed in chapter 5. Separate reporting of method (Chapter 4) and results (Chapter 5) avoids one very long chapter, and gives prominence to this central sub-study of the thesis.

4.1 Aims

The research aims (detailed in section 1.4) are restated here to guide the reader through the process from aims to chosen methodology and methods.

The broad research aim was to explore staff perspectives on supporting recovery, by investigating what staff say they do to support recovery. In line with grounded theory methodology, the precise research question and aims emerged from the data and the focus of the research became more refined as data collection and analysis progressed. Two specific aims emerged:

Aim 1: To identify staff perspectives on factors that help or hinder their efforts to provide support for recovery

Aim 2: To investigate staff understanding of recovery-orientated practice.

4.1.1 The rationale for developing a grounded theory

Research on perspectives of staff providing mental health services is a relatively unexplored area in need of further development (Berzins, 2006). The decision to use grounded theory was made following data collection at the first site where it became apparent that there is no accepted understanding of how recovery is, or can be, translated into practice and because staff perspectives on supporting recovery are relatively unexplored. Therefore, the overall aim of the study was to identify staff perspectives on supporting recovery and factors that help or hinder their efforts to provide support for recovery in NHS adult mental health services. Other qualitative approaches were considered before selecting grounded theory. For example, phenomenology was deemed inappropriate as the overall study aim went beyond the meaning for staff of their lived experiences (Van Manen, 1997), and while ethnography could have been used, it was infeasible in terms of the practicalities of fitting a research project into an existing programme of research (Holloway and Todres, 2003). However, grounded theory methodology was selected as most appropriate because it offered a systematic and rigorous methodology in an area where there is a dearth of research (Starks and Trinidad, 2007). It was also feasible in terms of integration into the wider REFOCUS programme (summarised in Section 1.2).

Grounded theory research also aims to explore variation and accommodates diverse perspectives of participants. It was felt that this feature would be advantageous considering the multiple conceptualisations of recovery-orientated practice. Grounded theory studies extend beyond preliminary, exploratory or descriptive research to the generation of theory (Anells, 1996). The decision to develop a new theory was also made following review of existing theoretical frameworks of implementation (Michie et al., 2005), and after considering the complexity of applying the frameworks to a new paradigm (discussed in Chapter 2) and to the specific group of staff participants in this study.

4.2 GROUNDED THEORY METHODOLOGY OVERVIEW

Grounded theory methodology places emphasis on the participant's perspective; focuses on experiences and social interactions to explain processes; and uses both inductive and deductive processes to arrive at a theory grounded firmly in the data.

Grounded theory constitutes both a method of enquiry and a method of analysis, in that it comprises a set of procedures for data collection and analysis, and a methodology (Denzin and Lincoln, 2000). Methodology refers to the principles that underlie the conduct of scientific enquiry. The principles extend beyond the research techniques and provide a link between the conduct of research and underlying theoretical underpinning and epistemological assumptions. Epistemology refers to the nature of knowledge itself, how it is obtained, what people know and how knowledge relates to concepts such as truth and belief. The method uses a continuous interplay of data collection, analysis and reflection (Bryant and Charmaz, 2007).

Grounded theory methodology was developed by Glaser and Strauss during their study *Awareness of dying* (1965), and was first presented in *The Discovery of Grounded Theory* by them in 1967, in response to the dominance of quantitative methods and the need to identify research methodology that extended beyond descriptive research to theory development (Glaser and Strauss, 1965, Glaser and Strauss, 1967). Existing qualitative methodologies were at the time criticised for lacking explicit methodological procedures. Developing a grounded theory is an iterative process using systematic data collection and analysis procedures designed to ensure scientific rigor. Emergent themes dictate future data collection and provisional hypotheses (statements about how concepts relate) are developed, verified and modified throughout the research process. Diverse sources of recruitment are encouraged to ensure theoretical sampling (see Section 4.3). Memo records of analytic decisions are kept and used to support theoretical sensitivity (see Section 4.4) and researchers are instructed to remain open to exploring a substantive area and to allow the primary concerns of participants to guide the emergence of core issues (Strauss and Corbin, 1990). Figure 4.1 illustrates the grounded theory data collection and analysis loop.

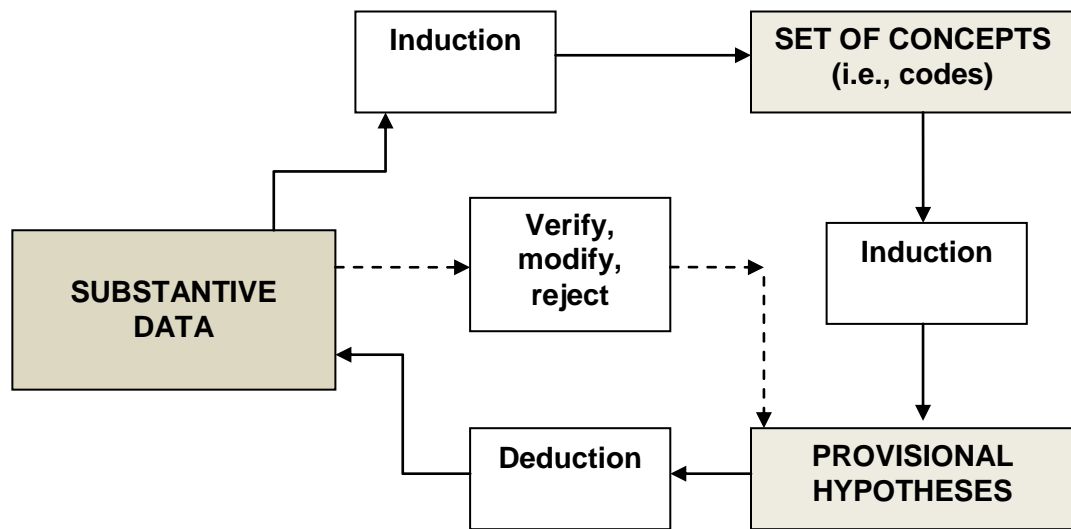


Figure 4.1: Data collection and analysis loop

Using grounded theory allows the researcher to have flexibility and freedom to explore a phenomenon in depth. There is an assumption that all of the concepts pertaining to the given phenomenon have not yet been identified, at least not in the population or place being studied. Relationships between the existing concepts may be poorly understood or conceptually underdeveloped (Creswell 1998).

4.2.1 Variations of grounded theory and differing theoretical orientations

The early work of Glaser and Strauss (1967) endorses a naïve realist ontology which argues that an objective reality exists (Glaser and Strauss, 1967). Glaser applied his positivistic methodology training in quantitative research and Strauss brought symbolic interaction to the collaboration. The researcher from the symbolic interactionist perspective is interested in discovering the realities of the research participants, the nature of the objects in their worlds and how they define and experience their world. The attempt to blend positivism and social interactionism traditions joined the rigour of positivist quantitative methods with the rich, interpretative approach of symbolic interactionism (Dey, 1999).

Since their original publication in 1967, Glaser and Strauss have developed different views on how to apply grounded theory, and a number of different variations to grounded theory methodology now exist. These inflections reflect a continuum of

differing theoretical underpinnings that question what knowledge is and how it can be acquired (Melia, 1996).

In 1978, Glaser published *Theoretical Sensitivity* which extended grounded theory beyond the original text (Glaser, 1978). In 1987, Strauss published *Qualitative Analysis for Social Scientists* (Strauss, 1987) and later collaborated with Juliet Corbin to produce *Basics of Qualitative Research* (Strauss and Corbin, 1990). This version aimed to clarify some of the more uncertain elements of *The Discovery of Grounded Theory* (Glaser and Strauss, 1967).

Glaser responded with his book, *Basics of Grounded Theory Analysis: Emergence Vs Forcing* (Glaser, 1992) in which he criticises Strauss for using prescriptive strategies and asking forced pre-conceived questions of the data. Glaser believed that data should be allowed to emerge and to tell its own story without forcing preconceptions and reiterates that categories will emerge if they are relevant. Strauss and Corbin (1998) clarify that the methodology and systematic tools outlined in *Basics of Qualitative Research* are to be used as a heuristic guideline (Strauss and Corbin, 1998).

The divergence in grounded theory methodology continues and a recent version has been proposed by Charmaz (2006) built on social constructivism (Charmaz, 2006). Social constructivism is rooted in pragmatism and relativist epistemology, and assumes that neither data nor theories are discovered, but are co-constructed by the researcher and participants (Burr, 1995).

Considering the different theoretical orientations of grounded theory methodology, Madill and colleagues (2000) conducted two independent grounded theory analyses of the same data, from i) a realist and ii) a constructionist epistemological viewpoint and found a substantial amount of agreement and integration between the two. The main differences were in the level of detail and the language used to describe the findings. This study counters critics of qualitative research, who are concerned with the level of reliability in subjective approaches and suggests that systematic qualitative research can contribute to uncovering the objective realities of the social world (Madill et al., 2000).

Chosen variation

The forced or emergent debate has been long discussed (Kelle, 2005) and it has been argued that if data are truly inductive, the researcher should trust in the emergence of concepts and wait to identify the version of grounded theory that fits the data rather than imposing a framework (Walker and Myrick, 2006, Bryant and Charmaz, 2007). In this study, the variations of grounded theory were considered alongside the emerging data, and the author decided to use the grounded theory version (first edition) developed by Strauss and Corbin (Strauss & Corbin 1990).

This version was considered a good fit because conducting a grounded theory study whilst also working on a larger programme of research, and bringing a clinical background to data collection and analysis (reported in Section 1.2) dictated the need for a modified approach to the methodology. Strauss and Corbin (1990) acknowledge the potential benefits of using literature and professional experience as sources of theoretical sensitivity (see Section 4.4). The role of literature is more relaxed, and can be used before and during the research process (Strauss and Corbin, 1990). Unlike Glaser's (1978) classic grounded theory, which advocates that theory can only be grounded in the data if the researcher approaches the field without assumptions from previous experience and learning (Glaser, 1978), this version recognises that researchers are able to approach the field with research problems and are able to draw on existing theoretical knowledge in order to understand and describe the phenomena being investigated.

The research presented here aimed to build a rich, explanatory grounded theory to characterise staff perspectives on supporting recovery. Strauss and Corbin's (1990) theoretical focus of symbolic interactionism (Strauss and Corbin, 1990) appeared to suit the emerging data where the focus on the participant's perspective, their experience and social interactions was beginning to explain the processes by which staff support recovery in their day-to-day practice.

Symbolic interactionism

The version (Strauss and Corbin, 1990) used in this study draws on symbolic interactionism. This section outlines the theoretical orientation of symbolic interactionism and provides examples of how this underpinning has shaped research decisions in this thesis.

Symbolic interactionism focuses on social interaction to explain human behaviour and thought, whereby human beings create meanings of the world around them through interaction with others and through their own internal dialogue. Individuals act reflexively with their environments in order to understand their realities and develop meaning in their lives (Mead, 1934). Grounded theory methodology therefore recognises the interrelationship between meaning and behaviour and aims to develop a theory that explains the action in the social context under study (Anells, 1996). The focus is on everyday life situations where processes, relationships, meanings and adaptations require explication, that is, to make the implicit explicit. The researcher attempts to discover the processes that people use to make sense of their situation (Walker and Myrick, 2006).

Blumer (1969) identified three basic assumptions behind symbolic interactionism:

1. "Human beings act towards things based on meaning that the things have for them".
2. "The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows"
3. "These meanings are handled in, and modified through an interpretive process and by the person dealing with the things they encounter" (p.2) (Blumer, 1969).

Symbolic interactionism was used in this study to explore how recovery support is communicated and what participants identified as their:

1. Perspective of recovery-orientated practice shaped by personal values and assumptions
2. Understanding of recovery-orientation developed through interaction with others (i.e. senior managers, colleagues, service users)
3. Perspective of recovery-orientation as shaped by environmental influences and other competing demands of practice.

In other words, how factors identified as important to recovery orientation (e.g. imposed time-limited input) interacted with participants' own personal sense of meaning (e.g. building meaningful relationships) to either facilitate or hinder their ability to support recovery. Participants' accounts were examined to explore how factors worked together to facilitate or hinder their ability to support recovery. Grounded theory recognises the interrelationship between understanding and action so participants' accounts focused on the understanding of recovery-orientated practice by sharing case

examples of what participants do to support recovery-orientated practice and case examples of what gets in the way of supporting recovery-orientated practice.

4.2.2 Research design

The grounded theory was generated following analysis of focus group and individual interview data. The research methods (focus groups and individual interviews) are described in Section 4.3.

The investigation started with the barriers and facilitators of implementing recovery-orientated practice in NHS community-based health care as an area of study, and what was relevant was allowed to emerge. The research became progressively narrowed and more focused during the research process, where provisional hypotheses were generated inductively from the data and tested with further data collection (Strauss & Corbin 1990).

4.3 PROCEDURES

Ten exploratory focus groups were conducted with team leaders (n=5) and other clinicians (n=5), within five NHS Mental Health Trusts in England (South London and Maudsley NHS Foundation Trust, 2gether NHS Foundation Trust, Leicestershire Partnership NHS Trust, Devon Partnership NHS Trust and Tees Esk and Wear Valleys NHS Foundation Trust). These were followed by individual interviews with clinicians, team leaders, and senior managers. Sites were purposively chosen for diversity (Pope and Mays, 2006) in geographical region of England, urban/rural balance and for perceived levels of success in implementing recovery-orientated practice (Shepherd et al., 2010).

4.3.1 Focus groups

Focus groups were used for early data collection as they stimulate discussion, provide group interaction between members, and can provide insight into the culture in which recovery support is operationalised (Morgan, 1997). They were used to identify barriers and facilitators to implementing recovery-orientated practice, highlight areas of agreement and disagreement, and provide an initial understanding of participants' experiences on implementing recovery support.

Sampling frame

Focus group participants were recruited from the aforementioned NHS mental health Trust sites. Team leaders and front-line staff in all adult community-based mental

health teams (CMHTs) using the Care Programme Approach (CPA) were included in the sampling frame. All team leaders were eligible to participate and staff were eligible if they had direct clinical contact with service users.

Purposive sampling

Grounded theory research assumes that people hold different perspectives of the phenomenon under study that cause them to act and interact in different ways. Grounded theory research aims to explore this range of perspectives as fully as possible. Therefore, purposive sampling based on selected participant characteristics that were considered possible to lead to different views and experiences was used. For example, site (Trust, type of team e.g. early intervention, support and recovery etc.) and staff characteristics (core profession, grade, job role) were used to maximise the range of views. The perspectives of staff from all professional groups were identified as critical to understanding the meaning of supporting recovery and how services can support or hinder recovery. The aim was to recruit a broad and diverse spread of participants and to build difference in the sample to reflect the full range of sub-groups and respondent characteristics.

Recruitment

Focus group participants were recruited from 41 community teams across five NHS mental health Trust sites: South London and Maudsley NHS Foundation Trust (n=6), 2gether NHS Foundation Trust (n=7), Leicestershire Partnership NHS Trust (n=9), Tees, Esk and Wear Valleys NHS Foundation Trust (n=9), and Devon Partnership NHS Trust (n=10).

Focus group participants were recruited from: Early Intervention Services (EIS) (n=6), Assertive Outreach Teams (AOT) (n=10), and Adult community mental health teams (sometimes called Support and Recovery or Rehabilitation teams) (n=23). Staff working in two specialist community teams, Supported housing and peripatetic services were also approached to participate.

Participants were approached and recruited by local Mental Health Research Network (MHRN) Clinical Studies Officers (non-London sites) or by the author (London site) by telephone, email or in person. The recruiters were mindful that staff have a large workload, feel stretched, and do not always consider research participation as part of their role (Jacobson et al., 2008). An organisational commitment was apparent across all participating sites and staff participation was managerially encouraged. Efforts were

made to present the research in a meaningful way, for example, engaging in a focus group was identified as an opportunity for staff to share their views.

A range of perspectives were sought alongside an opportunity for participants to share insights, so the aim was to recruit between 6-8 participants for each focus group. To achieve this, each Clinical Studies Officer (CSO) was provided with an information sheet (example included in Appendix 4) specific to their location. Invitation letters and study participant information sheets were provided to each CSO for dissemination (electronically and/or hard copy) to publicise the focus groups to team leaders in the first instance. All team leaders of NHS community adult mental health services (using the Care Programme Approach) were approached in each Trust. Team leaders were then asked to disseminate participant information sheets (PIS) to staff team members. A cross section of staff, with representation from all grades and professions was encouraged where possible e.g. activity co-ordinators, STR workers, care co-ordinators (nurses, social workers, OTs), vocational specialists, psychiatrists, and psychologists, alongside a spread of age, gender, ethnicity, and length of time in post. Team leaders and staff who were interested in participating were encouraged to contact the CSO or the author for details on location and times, and to ask further questions. The author was available by email and telephone to answer queries about the focus groups during the recruitment phase. The stages of recruitment are shown in Figure 4.2.

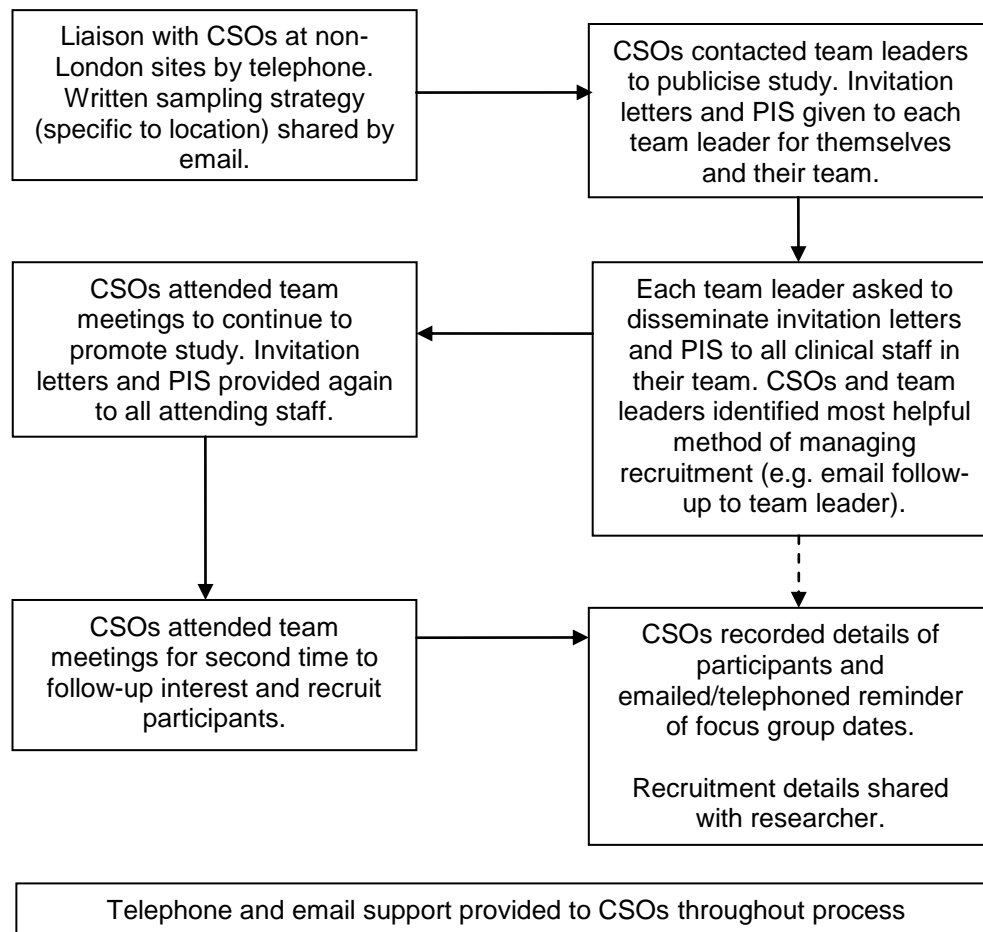


Figure 4.2 Stages of focus group recruitment

The invitation letter is included in Appendix 5. The focus group participant information sheet is included in Appendix 6.

Focus group format and topic guide development

Separate focus groups were conducted with team leaders and clinicians at each site to allow perspectives to be shared with others with similar managerial and clinical responsibilities. Each 90-minute focus group started by exploring staff perspectives on barriers and facilitators to providing recovery support. In line with grounded theory methodology, data collection was an inductive process and the topic guide evolved iteratively as new findings emerged.

As stated in Chapter 1, the first topic guide was developed before deciding on grounded theory as a suitable methodology and drew on existing implementation literature. Three core questions were developed to explore what participants think helps implementation, to explore what participants think hinders implementation, and to

explore what participants identify as potential solutions to implementation barriers. Prompts based on the Theoretical Domains Interview (Michie et al., 2005) were developed to support detailed discussion around the barriers and facilitators of implementation. The initial focus group topic guide is included in Appendix 7.

The initial topic guide was reviewed by the REFOCUS research team and piloted with 13 delegates attending a national occupational therapy conference where the author was invited to run a workshop on supporting recovery-orientated practice. The topic guide questions were presented to the workshop participants as a group and responses to both the structure of the questions and answers to the questions were elicited. The pilot confirmed that staff had many perspectives to share and were able to respond to the three core questions.

The conceptual framework of recovery-orientated practice (described in Chapter 3) was used in the early focus groups to organise the topic guide and generate discussion by providing examples of what recovery might mean in practice. Although the conceptual framework of recovery-orientated practice was developed from socially-constructed practice guidance documents and therefore does not reflect recovery-orientated practice in reality, it was considered a useful starting point for the research as it provided a link between existing guidelines and the research problem, staff perspectives on supporting recovery. However, individuals' interpretations of recovery-orientated practice emerged, prompting the lack of a shared understanding of what recovery means in practice to emerge as an early finding. The conceptual framework of recovery-orientated practice was not reflective of early staff perspectives and/or experience so was only used initially, and the research was instead led by the data. The many meanings of recovery support quickly became apparent as an influence on what was actually being implemented. Implementation factors could not be considered without this context. Barriers and facilitators to providing recovery support were also identified as an influence on how staff understood recovery as applied to their practice. One example is that participant understanding was frequently informed by system messages such as recovery equals service throughput.

While participants shared their views and attitudes, few were able to provide examples of using a recovery approach in practice. Where staff were unable to draw on experience to elicit practice examples of supporting recovery, perceptions of practice were sought. The aim to investigate what staff say they do to support recovery was subsequently added and the topic guide was amended iteratively. The research

became progressively focused and theoretical explanations were tested and revised with further data collection.

Nine focus groups were led by the author, and on one occasion, a researcher with an academic psychology background led the group. Having the same moderator for the focus groups ensures the same issues are addressed across all groups and assists analysis (Pope and Mays, 2006). Four of the ten focus groups were moderated by an additional researcher (one with an academic psychology background and one with an occupational therapy background). Focus groups took place between May and August 2010, and were audio recorded and transcribed verbatim immediately after each site visit.

4.3.2 Individual interviews

Focus group data analysis suggested a methodological limitation, where participants had difficulty in eliciting individual accounts of recovery-orientated practice in a group context. The difficulty in eliciting individual practice examples may have been because the focus group setting creates jointly produced participant accounts that give insight into "public" discourses, that is, perspectives expressed with a group of peers, which may be different from "private" views expressed in individual interviews (Smithson, 2000). Individual interviews were therefore conducted to allow deeper probing to explore individual practice examples alongside barriers and facilitators to supporting recovery.

Sampling frame

Individual interview participants were recruited from four NHS mental health Trust sites: South London and Maudsley NHS Foundation Trust, 2gether NHS Foundation Trust, Leicestershire Partnership NHS Trust, and Tees, Esk and Wear Valleys NHS Foundation Trust, chosen to provide a mix of different English regions (Midlands, South East, North East), levels of urbanisation, socio-economic deprivation status, ethnic diversity, organisational size and structures (Foundation or non-foundation), and perceived levels of success in implementing recovery-orientated practice.

Team leaders and front-line staff in all adult community-based mental health teams (CMHTs) using the Care Programme Approach (CPA) in each Trust were included in the sampling frame. All team leaders were eligible to participate and staff were eligible if they had direct clinical contact with service users. The sampling frame was extended to include NHS Trust senior managers.

Theoretical sampling

Theoretical sampling is a defining feature of grounded theory methodology (Strauss and Corbin, 1990) where participants are sought that are thought to be able to contribute further data relating to provisional hypotheses and the important emerging theoretical constructs, so that the constructs can be examined and elaborated further.

Interview participants with a range of characteristics were sought to test out and refine the emerging theory (Strauss and Corbin, 1990). For example, questions arose from the data following interviews with newly qualified staff, which led to clinicians and team leaders with greater work experience being more actively recruited to examine whether they were more likely to support recovery.

Questions also arose following interviews with participants who identified themselves as successful in supporting recovery in practice. Staff and team leaders participating in the REFOCUS national survey (Leamy et al., 2016) (a component of the REFOCUS programme of research outlined in Section 1.2) were included in the sampling frame if they perceived themselves as recovery-orientated. The survey used the Recovery Self-Assessment (RSA) to measure self-perceived levels of recovery-orientation (O'Connell et al., 2005). The RSA has parallel versions for team leaders and staff, and has 36 items to rate practices associated with supporting recovery. Participants rate the degree to which they engage in the practice on a 5-point Likert scale from 1 (Strongly disagree) to 5 (Strongly agree) or Not applicable. The RSA can be scored as a total sum score ranging from 36 (low recovery orientation) to 180 (high recovery orientation; $\alpha = .94$) or as five sub-scales: i) Diversity of treatment options ($\alpha = .72$), ii) User Involvement and Recovery Education ($\alpha = .84$), iii) Life Goals vs. Symptom Management ($\alpha = .88$), iv) Rights and Respect ($\alpha = .61$), and v) Individually-tailored Services ($\alpha = .64$). Mean RSA scores were used to identify potential interview participants on a range from 36 (low recovery orientation) to 180 (high recovery orientation). Another component of the REFOCUS programme was the REFOCUS randomised controlled trial (RCT) process evaluation. As part of the process evaluation, the author was responsible for conducting three interviews with trainers to explore their experiences of delivering training (recovery and coaching) and working with individual teams. Staff members who reported an ability to support recovery were identified by the trainers and included in the theoretical sampling frame of the grounded theory study, to investigate factors that enabled their success.

The large amount of data relating to the organisational influence on supporting recovery-orientated practice also directed the author to include senior NHS managers in the sampling frame, to examine the organisational factors identified as instrumental in shaping the meaning and success of supporting recovery.

Differences in the sample such as models of service delivery (early intervention, assertive outreach, recovery) or core professions (psychiatrists, CPNs, occupational therapists) were also explored.

Recruitment

Individual interview participants were recruited from 18 community teams across four NHS mental health Trust sites: South London and Maudsley NHS Foundation Trust (n=9), 2gether NHS Foundation Trust (n=3), Leicestershire Partnership NHS Trust (n=2) and Tees, Esk and Wear Valleys NHS Foundation Trust (n=4). In addition, senior managers were recruited from South London and Maudsley NHS Foundation Trust.

Sources of interview participant recruitment were Adult NHS community mental health services: Early Intervention Services (EIS) (n=4), Assertive Outreach teams (AOT) (n=1), Forensic teams (n=1) and Adult community mental health teams (CMHTs) (sometimes called Support and Recovery teams) (n=12).

Interview participants were approached and recruited by the author or a researcher with an academic psychology background (London site), the 2gether REFOCUS research team (2gether site) or local MHRN Clinical Studies Officers (non-London sites) via the telephone, email or face-to-face. The invitation letter is included in Appendix 5. The interview participant information sheet is included in Appendix 8. Recruitment continued until theoretical saturation was reached.

Theoretical saturation

Sampling should end when the research reaches what is termed, "theoretical saturation". This occurs when the researcher believes that the devised categories and sub-categories have been fully explored and that new data are easily accommodated within them. Strauss and Corbin (1990) point out that the researcher must seek diverse groups of participants to ensure that saturation is based on the widest possible range of data on the category (Strauss and Corbin, 1990). However, it helps to view theoretical saturation as a goal rather than an actuality, as the development of theory is an open process in which the modifications of categories are always possible.

Interview format and schedule development

The interview schedules, one for clinicians and team leaders and one for senior managers, focused on using practice examples of recovery orientation to identify blocks and enablers to incorporating recovery into routine clinical practice. Initial interview schedules were informed by focus group findings, piloted to ensure individual level responses could be elicited from the questions and revised iteratively to further explore emergent themes and deviant cases. For example, the category "competing priorities for practice" was introduced in focus group data and subsequently explored. Staff and team leaders were asked 'What are your priorities and goals for practice? Describe how, and to what extent you have been able to implement recovery-orientated practice'. Senior managers were asked 'Can you describe how this organisation supports recovery? What do you see as the current organisational priorities?'

The two initial interview schedules were also informed by a local MHRN Patient and Public Involvement (PPI) group called Feasibility and Support to Timely recruitment for Research (FAST-R) who offer expert advice and expertise to ensure research information is easily understood. Their input led to changes in the language used in the questions to enhance clarity. Example staff interview schedules are included in Appendices 9 (version 1) and 10 (version 5) and an example senior manager interview schedule is included in Appendix 11.

Interviews were conducted across NHS sites, lasted around one hour, and were audio recorded and transcribed verbatim. Where requested, transcripts were returned to participants for comment and correction. Interviews were conducted by the author or a researcher (with a background in academic psychology). Two interviews conducted by the 2gether research team (with backgrounds in academic psychology and/or as a clinical support worker) were used to ensure theoretical saturation. All interviews were conducted between January 2011 and August 2012.

4.3.3 Research Ethics Committee (REC) approval

As part of the REFOCUS study (ISRCTN02507940), REC approval was obtained from Joint South London & Maudsley and the Institute of Psychiatry NRES (10/H0807/4) and East London NRES (11/LO/0083). Research and development approval was obtained from all participating Trusts.

All participants gave consent to participate and for their responses to be used in publications. The focus group participant consent form is included in Appendix 12. The individual interview consent form is included in Appendix 13.

4.3.4 Ethical aspects of the research

All participants were provided with an information sheet during the recruitment phase of the research. The same information sheet (included in Appendix 6 and 8) was provided again at the beginning of data collection and participants were encouraged to ask any questions. Informed consent was requested and participants completed a consent form (included in Appendix 12 and 13).

Effort was made to ensure participants felt as comfortable as possible about sharing their perspectives. Focus groups and interviews were conducted at a time and place convenient for participants. This was most often at the staff member's work place, but could be anywhere where participants felt safe, that they would be undisturbed, and that was private and quiet. Where participants were placed with colleagues and fellow team members in focus groups (to allow sharing of views in similar job roles and to enhance peer support), the author was mindful of the tendency towards a normative discourse and for socially acceptable opinions to emerge (Smithson, 2000). Efforts were made to allow a safe space for sharing perspectives and the voluntary nature of participation was emphasised; participants were assured that they did not have to answer questions if they chose not to, and that they could withdraw at any time without penalty and that their current and future employment would not be affected. Emphasis was placed on the importance of all views and it was explained that there were no right or wrong answers. Focus group participants were asked to respect each other's views and assured that consensus was not required. It was reiterated that there was no need to share personal experiences unless participants wanted to. Participants were informed that their views would be confidential and treated as anonymous, and that only members of the research and transcribing team would have access to their responses. Focus group participants were asked that information shared in the focus group remain confidential. All paper records were kept secure in a locked filing cabinet and electronic records were password protected.

Introductions by CSOs at non-London sites helped to build a positive relationship with participants and to begin to establish trust with the researcher. Participants were reassured that they would not be judged and that honesty would be respected. To help establish rapport, the researcher gave some information about herself, explained the

impetus for the research, and her previous role in clinical services. There were times of mutuality during the data collection process where the author would be asked to provide her view or additional information on recovery-orientated practice. Having a moderator from a similar background is also recognised to reduce moderator bias (Holloway, 2005).

Efforts were also made to avoid causing distress or embarrassment and to lessen potential frustration caused by disclosing concerns about current practice or by highlighting the dissonance between motives for entering the career and current practice. For example, discussing recovery-orientated practice may have led to disclosure of conflict between professional and personal values. In this case, the author was able to reassure and to draw on her previous clinical experience in a similar role. The opportunity for staff to debrief or to follow-up items discussed during data collection was also offered.

4.4 Data analysis

SPSS (version 17) (IBM Analytics, 2008) was used to perform descriptive analysis of participant demographic data. Iterative analysis of the data was undertaken in line with grounded theory methodology as developed by Strauss and Corbin (1990). Data analysis was conducted concurrently with data collection using NVivo QSR International qualitative analysis software (version 8) (QSR International Pty Ltd, 2008). Focus groups and interviews were transcribed (by the author, the research administrative support team and an outside agency) and coded as soon after the event as possible so that themes identified through coding could be explored with subsequent data collection. The author led and managed the analysis. Audio files were accessed and transcripts were read repeatedly to allow the author to become immersed in the data, to listen to what was said as well as how it was said, and to check the accuracy of transcripts.

To enhance feasibility, two focus groups were held on the same day at each site (one for staff and one for team leaders). Audio files were transcribed as soon after each focus group as possible and analysis commenced prior to conducting focus groups at the next site. Focus group data analysis was conducted between May and December 2010.

In line with grounded theory methodology, attempts were made to conduct sequential interview data collection and analysis. In terms of research practicalities, interviews

conducted at non-London sites were scheduled for the same day. In these cases, interviews were transcribed and analysed in the order in which they were conducted. Written notes on immediate impressions were kept throughout the whole data collection process. Interview data were coded alongside focus group data, and data analysis continued from January 2011 to October 2013.

Data collected in a grounded theory study are analysed using constant comparative analysis. Constant comparative analysis involves coding a unit of data and comparing it with all the other units of data coded in that emergent category. It is a systematic tool for developing and refining the theoretical properties of a category and assists the researcher to move from a simple description of the participants' categories to a more theoretical level. It also allows the analyst to question assumptions (e.g. newly qualified staff are more able to demonstrate recovery-orientated practice examples) by comparing data. To enhance the coding approach, staff and team leader transcripts were analysed alongside each other.

Although data analysis is non-linear, there are three stages to the constant comparison method: 1) open coding (examining, comparing, conceptualising, and categorising data), 2) axial coding (reassembling data into groupings based on relationships and patterns within and among the categories identified in the data), and 3) selective coding (identifying and describing the central phenomenon, or 'core category' in the data) (Strauss and Corbin, 1990). Theoretical notes were kept throughout to record the coding process.

4.4.1 Open coding

Line by line open coding was used to identify emerging concepts. An example of open coding is provided below:

I: "Is there anything else that you want to say about recovery-orientated practice?"

P: "I get it. I just don't know it's always black and white if that makes sense. I think it's something that can be interpreted lots of different ways by lots of different people and we've all got our own ways of doing it – and that's as a Trust. That's two parts isn't it, on an individual basis and what we can do in terms of the demands on us from the people we work for."

*Agree with recovery approach
Recovery support is complex*

Different things to different people

Individual interpretation of recovery support

Competing priorities

4.4.2 Axial coding

Axial coding was conducted to organise and propose relationships among concepts. Data were compared to identify similarities and differences between them. Similar concepts were grouped together to form a category and concepts became less specific and more abstract. The conditional matrix analysis procedure was used to determine the scope of study by identifying relationships between micro (individual) and macro (organisational) conditions. An example theoretical memo is detailed below and illustrates the author's thoughts on the coding process when considering properties and dimensions of categories.

Prioritising recovery-orientated practice:

*What attributes distinguish those who prioritise over those who do not?
Is it where you work, what you do (your job), or who you are?*

Property = primacy to recovery/prioritising recovery

Dimension = A focus of practice/intrinsic - add on

Frequency = Always considers - never considers

Thematic maps were used to organise the categories by clustering all codes according to connections in the data, and by considering the patterns and relationships between them. Figure 4.3 illustrates a visual thematic map used to organise relationships between sub-categories and to help identify the core category.

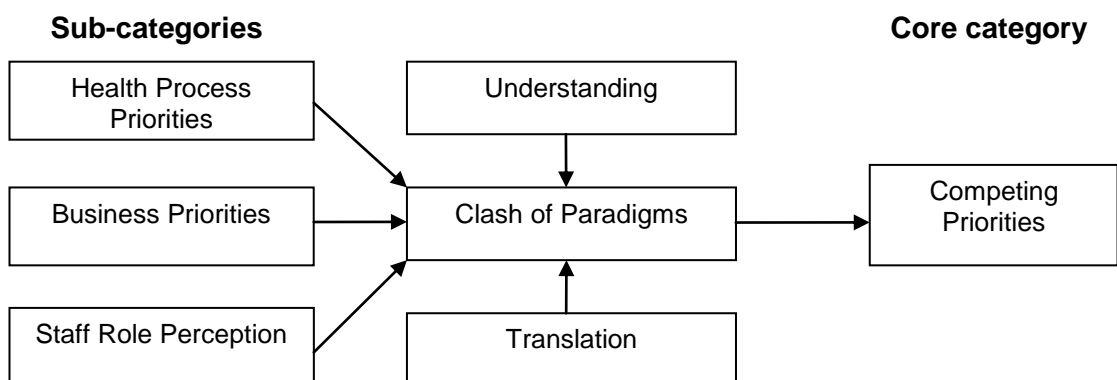


Figure 4.3 Thematic map

The three sub-categories that emerged from the open coding process represented multiple meanings of recovery-orientated practice. The sub-categories were connected together because they influenced how participants' understood and translated recovery in to practice. A clash of paradigms was identified as the central connection that

included all of the data, that is, a conflict of values, leading to a core category of competing priorities.

4.4.3 Selective coding

Open and axial coding led to the development of categories and eventually a core category emerged. Coding then became more selective and proceeded to fully explore the core category and its relationships. The core category is the central theme and relates to as many of the other themes as possible, linking the data together and explaining variations of the data.

Selective coding was undertaken to further integrate and refine categories. One analytic technique designed to facilitate integration is to write a storyline memo. The analyst notes down a descriptive story of 'what seems to be going on', the emerging story line is described, and categories that require further development are explored. An example of selective coding using the story line technique is illustrated in the author's memo below:

'We all want the same thing...to support recovery – but the concept has different meanings at different levels of the system (and between different actors within the system) – and the 'definition' has been lost. All seeking to achieve something different called 'recovery-orientated practice', more often than not according to own priorities or priorities imposed by the system not the service user.'

4.4.4 Theoretical sensitivity

Theoretical sensitivity was used to enhance analysis. Theoretical sensitivity is the ability to identify important concepts, to give meaning and to indicate relationships within the data. The degree of theoretical sensitivity (personal perspective, pre-existing ideas and assumptions) comes from a number of sources including the researchers' previous reading, professional experience, personal experience and the analytic process itself. While these sources support sensitivity, data analysis decisions must remain transparent to ensure that the theory is grounded in the data (Barnes, 1996).

Reflexivity, defined as attending to the effect of the researcher on the context of knowledge construction, enables the researcher to acknowledge their role in the research process, to recognise bias, and allows the theory to emerge rather than forcing it to fit preconceived ideas (Finlay and Gough, 2003). Attempts were made to remain faithful to the participants' perspective and to ensure the authenticity of the research. While it might be questioned whether too much reading around the topic prior to starting the research means the researcher was unable to approach the field without

preconceived ideas, it is also argued that background knowledge of the area is required before deciding on whether or not grounded theory is an appropriate methodology (Annells 1996). As soon as the decision to use grounded theory was made, the author placed limits on her reading, and read only for the wider REFOCUS study (summarised in Chapter 1) with which she was involved. The author conducted a systematic review (reported in chapter 6) and a narrative review (detailed in chapter 2) specific to staff perspectives after the grounded theory was developed. All efforts were made to avoid making assumptions based on previous reading.

Relationality, defined as attending to the effects of researcher-participant interactions on the construction of data and to power and trust relationships between the researcher and researched, was also examined and a diary was kept to record personal reflections on the author's developing role and transition from clinician to researcher (Hall and Callery, 2001). In particular, the dynamics of the researcher-researched relationship and the co-construction of the research experience were explored (Finlay and Gough, 2003). For example, the author considered her own understanding of recovery-orientated practice, and previous experience of working in mental health services. Relationships with some participants in the London site were established prior to study commencement where the author had previously worked in a clinical role (reported in Section 1.2). Other participants were informed of the author's previous clinical role and that with this background she had a particular interest in staff perspectives on supporting recovery. The author also had some awareness of the London-based services to which participants referred to illustrate their accounts.

A particular focus was also given to intersubjective reflection, and to how unconscious processes structure relations between the researcher and the participant (Finlay and Gough, 2003). Of interest was the ability to manage power imbalance in the relationship, to become mutual and to deconstruct the author's authority as it was acknowledged that working on a large programme of research at an influential institution could easily contribute to power imbalance. For example, disclosing the author's previous clinical role was considered to assist with building rapport and heightening identification with other clinicians. The author also used subjective feelings (from clinical experience) to probe participant accounts. Alongside a personal diary, two strategies were used to examine the influence of the author on shaping the research process, and to record thoughts, analysis interpretations, questions and directions for future data collection. These strategies were theoretical memos and multiple coding.

Theoretical memos

Memos including initial impressions, ideas and hypotheses, and reflections on the author's role in the research process were kept so that the developing theory emerged from the data rather than being made to fit preconceived ideas. Here is a memo (outlining initial impressions) that influenced the author's subsequent approach.

07/01/11

Participant 121 considered herself pro-recovery but when asked, she identified difficulty in providing examples of recovery-orientated practice. Did she feel put on the spot? 'Can you give me an example of a time you have supported a person's recovery...?' Maybe I could encourage participants to integrate case examples into their answers rather than asking the question outright? Why is it so difficult for some people to identify a case example? Does it relate to the understanding of recovery support – just good practice (implicit)?

In conversation, she spoke mostly about recovery orientation in terms of 'moving-on' – defined as discharge from services, and viewed recovery support as competing with and separate to other working practices e.g. CPA, care coordination, personalisation. Practice examples illustrate the meaning of recovery-orientated practice to each participant. Do I need more direct questions on meaning? Would a different methodology produce a different result?

Working on a programme of research provided rich opportunities for theoretical sensitivity. Here is a memo made following two REFOCUS baseline trial interviews (Slade et al., 2015a) where service users explained that staff did not ask them about recovery. The interview schedules were revised and clinicians and senior managers were specifically asked if and how they prioritise recovery-orientated practice.

17/05/11

Service user 1: very positive about experience of services – and recovery support – spoke about achieving a meaningful life – even though said didn't know what 'recovery' is. Spoke positively about choice, hope, empowerment etc.

Do staff talk to people about their recovery? Do staff offer opportunities for service users to explore what recovery means for them? Do staff use the word 'recovery'?

Service user 2: felt it's not possible to recover as there is no cure for schizophrenia. Care coordinator 'treats me as a patient with schizophrenia'.

Who defines recovery? Is recovery imposed by staff where staff say what it means e.g. no cure for schizophrenia, depot etc.

A further theoretical note identifies the complexity of defining recovery-orientated practice.

06/04/11

Barrier to implementation = complexity in defining recovery. How can we research implementation when it is not clear 'what' we are implementing?

14/08/11 Refocus context

Is implementing recovery support different to implementing any other complex intervention? Do the many meanings complicate its use?

Multiple coding

The author discussed her opinion on the emerging themes with PhD supervisors, study colleagues and the wider research community (i.e. recovery research network meetings and conferences). This forced the author to reflect upon and justify her interpretation of events. Multiple coding also provided a formal mechanism for comparing interpretations of data and provided an opportunity to reflect on and enhance the awareness of the coding approach. The author and one researcher independently coded three interviews and then compared their coding strategies. Diverse interview transcripts were chosen in which one female psychiatrist working across teams, one newly qualified female nurse working in an early intervention service and one experienced male nurse working in an assertive outreach team expressed varied perspectives. The author and two PhD supervisors provided different perspectives, coming from different disciplinary backgrounds and with different research interests. The author's note recorded differences in opinion.

15/06/2011

Different understandings of recovery-orientated practice – author with a clinical background = collaboration where staff and service users are experts together – find a common-ground where experience of mental illness and professional input come together and work in partnership. Supervisor 1 views recovery as staff moving to service user priorities and perceives collaboration as a compromise. Supervisor 2 questions the point of staff if not bringing professional input.

Debates regarding rigour and validity criteria in qualitative research continue (Whitemore et al., 2001). Grounded theory methodology provides a set of highly systematic tools which confer rigour on the research process that include theoretical sampling and constant comparative analysis as well as strategies to enhance theoretical sensitivity (including the use of memos and multiple coding) (Chiovitti and

Piran, 2003). These strategies were used to install rigour in the research process and to ensure that the developed theory represents the phenomenon under study (Hammersley, 1992).

4.5 Summary

This chapter set out the procedures that were followed and described how the grounded theory evolved. Efforts have been made to provide a full description of each stage of data collection and data analysis. The rigour of grounded theory methodology offers researchers a set of clear guidelines from which to build explanatory frameworks that specify relationships among concepts.

The developed theory is a result of the interrelationships between a central phenomenon or "core category" and all the other sub-categories (Strauss and Corbin, 1990) identified as influences on the success of implementing recovery support in mental health services. Each category is presented and illustrated with quotations in Chapter 5.

Chapter 5. Competing Priorities

Chapter 4 described the iterative procedures that were followed to generate the grounded theory. In line with conventional practice within grounded theory research, Chapter 5 reports the final theory (rather than the process of interpretation) and provides a discussion on the implications for practice. The developed theory is a result of the interrelationships between a central phenomenon or "core category" and all the other sub-categories (Strauss and Corbin, 1990) identified as influences on the success of implementing recovery support in mental health services.

The grounded theory of staff perspectives on supporting recovery has been published (Le Boutillier et al., 2015b), and is included in Appendix 21.

Chapter 5 comprises three sections. Section 5.1 presents participant characteristics. The grounded theory is reported in Section 5.2, and the implications for policy and practice are discussed in Section 5.3.

5.1 Participants

The grounded theory was generated following analysis of 10 focus groups and 32 individual interviews. A total of 65 staff (clinicians and team leaders) participated in focus groups, and 32 staff (clinicians, team leaders and senior managers) in interviews. No participant took part in both a focus group and an interview. Participant characteristics are shown in Table 5.1.

n (%)	Focus groups n=65	Interviews n=32
Job role		
Clinician	34 (52.3)	18 (56.3)
Team leader	31 (47.7)	6 (18.8)
Senior manager	0 (0.0)	8 (25.0)
NHS Trust		
South London and Maudsley NHS Foundation Trust	13 (20.0)	16 (50.0)
2gether NHS Foundation Trust	14 (21.5)	10 (31.3)
Leicestershire Partnership NHS Trust	12 (18.5)	2 (6.3)
Tees, Esk and Wear Valleys NHS Foundation Trust	13 (20.0)	4 (12.5)
Devon Partnership NHS Trust	13 (20.0)	0 (0.0)
Team		
Assertive Outreach	15 (23.1)	1 (3.1)
Early Intervention	12 (18.5)	4 (12.5)
Forensic	0 (0.0)	1 (3.1)
Support and Recovery	32 (49.2)	18 (56.3)
Rehabilitation	2 (3.1)	0 (0.0)
Supported housing	2 (3.1)	0 (0.0)
Management	0 (0.0)	7 (21.9)
Works across teams	2 (3.1)	1 (3.1)
Profession		
Psychiatrist	2 (3.1)	2 (6.3)
Nurse	40 (61.5)	17 (53.1)
Social worker	7 (10.8)	2 (6.3)
Occupational Therapist	9 (13.8)	5 (15.6)
Psychologist	1 (1.5)	2 (6.3)
Associate practitioner	0 (0.0)	1 (3.1)
Vocational Specialist	1 (1.5)	1 (3.1)
Support time and Recovery worker	2 (3.1)	1 (3.1)
Support worker	2 (3.1)	0 (0.0)
Exercise and health practitioner	1 (1.5)	0 (0.0)
Manager (no clinical background)	1 (1.5)	1 (3.1)

Table 5.1: Grounded theory staff participants (n=97)

The mean age of staff was 45.2 years (range 24-61, s.d. = 8.5), and time working in mental health services ranged from 6 months to 35 years. The mean number of years qualified was 18 years 6 months (range 30-396 months, s.d. = 123.0) with current pay grades ranging from Agenda for Change band 2 to consultant. The highest academic qualification of participants ranged from National Vocational Qualification (NVQ) Level 4 to PhD level study. Of the interview participants, six (19%) members of staff disclosed personal experience of mental illness, four (12.5%) disclosed experience of

using mental health services and eighteen (56%) disclosed experience of supporting a family member or friend with mental illness. Additional characteristics of staff participants are shown in Appendix 14.

5.2 Core category and sub-categories

The developed theory is a result of the interrelationships between a central phenomenon or "core category" and the sub-categories (Strauss and Corbin, 1990) identified as influencing staff perspectives on supporting recovery. Findings identified a difficulty in articulating examples of recovery-orientated practice and often examples of what recovery does not mean in practice were provided instead. Despite the study focus on success stories, staff appeared to identify more barriers than facilitators to supporting recovery. An early finding was that barriers and facilitators identified by staff shaped their understanding of recovery as applied to practice.

The core category to emerge from the data was Competing Priorities. Participants' accounts of recovery-orientated practice appeared to be informed by priorities across different levels (for example, organisational level, staff level etc.) of the health system. One major challenge for participants was understanding recovery-orientated practice. Three sub-categories relating to the competing priorities and the compromises that staff feel have to be made when supporting recovery were identified. The Health Process Priorities category reflected traditional mental health concerns, including a focus on symptomatology and functioning, and the evidence-based medicine view of scientific knowledge. The Business Priorities category involved a view of recovery as a service outcome, with potential trade-offs between quality and quantity. The final category, Staff Role Perception, captured staff views of their role in supporting recovery, which ranged from a custodial orientation to a recovery-orientated model of care, with a corresponding focus of practice from narrow (primarily symptomatology) to a more holistic emphasis.

The findings of a theory are often presented diagrammatically to demonstrate how the core category relates to the other dominant themes. The grounded theory is illustrated in Figure 5.1.

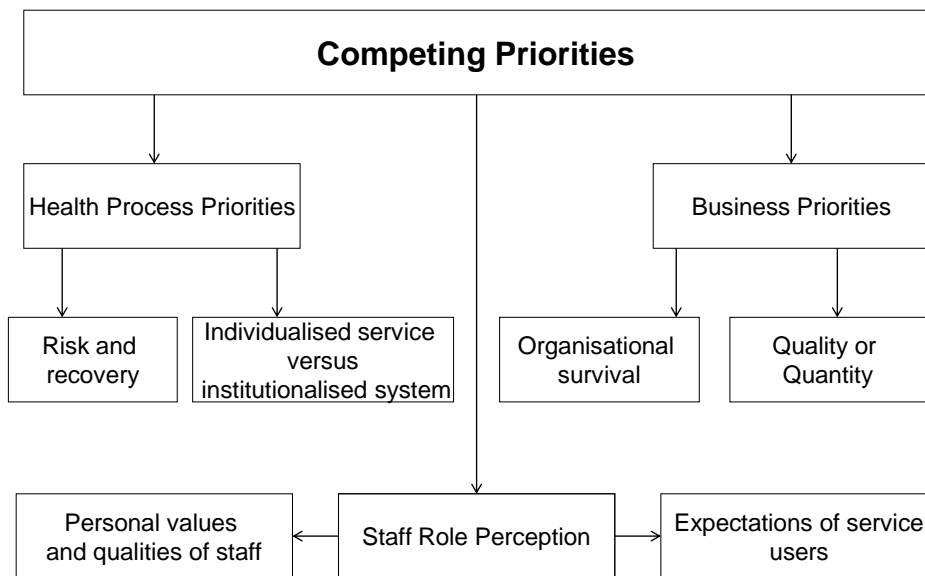


Figure 5.1 Grounded theory of staff perspectives on supporting recovery

The core category and each sub-category will now be described in detail. The full grounded theory coding framework is included in Appendix 15.

5.2.1 Core category: Competing Priorities

Although staff identified with the notion of recovery, recovery was supported in a number of ways and diverse understandings and translations were evident, based on competing priorities within and between the different layers of the health system. Health organisations incorporate the socio-political context, organisational structure, role and function of teams, role of staff, and relationship between staff and service users, which all combine to influence the success of services in supporting recovery. Discrepant priorities across these different levels of the health system led to a clash of paradigms and competing agendas in supporting recovery, with practice most often dictated by power within the system. Recovery support was identified as being commandeered where health system and organisational priorities take precedence.

'The problem is (recovery's) at odds with the way the NHS is run basically, the way in which funding streams are decided, and everything else, it doesn't really fit. My understanding of the current ways in which we're being told to do things like four contacts a day, that we've got to have people within certain clusters... I think it takes our ability to function as independent clinicians out of the mix and

it takes being able to treat clients as individuals and unique people out of the mix as well.' (Occupational therapist, CMHT)

Staff identified the need for a shared understanding of what recovery is and how it can be supported across the whole system. One team leader stated: *'There needs to be consistency, it needs to be at all levels of the organisation in terms of the recovery model.'* (Team leader, social worker, AOT)

Another participant stated that recovery support lacks involvement at the socio-political level and called for societal attitudes toward mental illness to be challenged.

'Promoting recovery is everyone's responsibility. It's not just the carers, it's not just the health service but it's the employers, it's the police, it's society as a whole. Because it's all very well us promoting recovery but then if people go off into society where stigma and discrimination takes place and people's attitudes are very closed, I think all our good work comes to nothing really.' (Vocational specialist, CMHT)

5.2.2 Sub-category: Health Process Priorities

One of the sub-categories to emerge strongly in participants' accounts was Health Process Priorities. Participants suggested that the meaning of recovery support has been altered to fit a health infrastructure where its meaning is shaped by a traditional focus on hierarchy, clinical tasks, professional language, medicalisation and psychiatric power.

'...an organisation like ours, which is predominantly medically oriented, has a history of clinical expertise so there has been this understanding of recovery as getting better. I think it's wider than that, a lot of people think it's wider than that but how that's actually illustrated in practice people struggle with because we still want to treat people and help them 'get better'.' (Senior manager, occupational therapist)

5.2.2.i Individualised service Vs institutionalised system

The conflicting tension of delivering an individualised service in an institutional system caused concern.

'We made quite a strong bid to set [an electronic system] up using recovery values to name and determine the fields so it could actually support recovery-based thinking and practice. Perhaps rather typically, we were told that it was an off-the-peg suite of forms and we had to work with it. And that tension as to whether you can personalise things and get them to serve the outcomes or whether you're taken hostage by them and you have to serve the system is a kind of pretty standard institutional tension really.' (Psychiatrist, CMHT)

Service systems that focus on service priorities, for example, recording personal recovery plans that are the property of services and not people were also considered incongruent with providing individual recovery support.

'There's a dilemma that's represented by the concept of a 'personal recovery plan'. We've got this phrase, and there's a Trust objective that everyone should have a personal recovery plan. But it doesn't belong to the person, it actually belongs to the worker, and it's completed by the worker and yet it's called a personal recovery plan.' (Psychiatrist, CMHT)

The same problem applied to service structures that focus on diagnosis.

'I think there's something about working holistically as well, not just working with someone's diagnosis or someone's symptoms...I think the message that we give to them is really important. If we give them the message that they're ill, give them a diagnosis of schizophrenia, I think that's shockingly awful. I think it's about seeing beyond the diagnosis and beyond the symptoms and actually working with what else is important to that person.' (Psychologist, EIS)

Another participant stated: *'I think what we were trying to do was come away from diagnosis and more about how that person experiences any symptoms or the experiences they have to do with their mental health, rather than saying well that is this, because what we're now doing is putting them much more firmly into diagnosis and into boxes.'* (Nurse, CMHT)

Despite these factors, staff felt some service structures and health models can successfully support recovery. Workers of early intervention and assertive outreach teams reported more opportunities to support recovery, possibly due to lower caseloads.

'I do believe that to be able to deliver more effective recovery-led treatment packages, you need to have lowered caseloads so you can actually spend quality time with patients.' (Nurse, CMHT)

It was considered helpful that early intervention focus on early onset and assertive outreach focus on hard to reach cases. Conversely, recovery and support teams were identified as lacking a practice model.

'I notice a difference at [early intervention service], they're very good to get in there early and try and maximise recovery. I also feel that assertive outreach, even though they have to be creative about the way they engage people, I think they're very good at it... And I think sometimes the people in [recovery and

support teams] are not quite as focused on that or they get a bit lost in the middle.’ (Psychiatrist, across teams)

A multi-disciplinary team approach was also considered fundamental in order to address health process priorities.

‘I think there are some people who think very much that maybe recovery is more psychosocial and then there’s medical prescribing and stuff...and they might see that as sort of different. I think it depends on how cohesive everybody is in the team, how much the medic is part of that. Like I’m very involved in multi-disciplinary formulation in our team and sort of, looking at lots of different aspects of what’s going on for this person.’ (Psychiatrist, across teams)

5.2.2.ii Risk and recovery

Health processes were found to shape recovery-orientated practice and present barriers to recovery support. Where participants felt able to support recovery, the concept was translated to fit service structures, and was framed in clinical language and systems. In some instances, supporting recovery in a traditional health model was felt to compete with core medical tasks. For example, the relationship of recovery to the statutory clinical obligation of risk management was seen as a competing priority.

‘That is still a core part of care-coordination, you have to make sure that people have their medication and they’ve been risk assessed and they’ve been mental stated. Because otherwise, the organisation would say that you hadn’t done your job properly.’ (Team leader, occupational therapist, EIS)

Staff felt they would encourage recovery support through positive risk-taking if they were better supported by the organisation.

‘People will always batten down the hatches and that’s quite a natural thing to do. Because if you look at taking therapeutic risks and they do go wrong, I’m not sure that our Trust supports you as well as they should be supporting people.’ (Team leader, nurse, AOT)

5.2.3 Sub-category: Business Priorities

Another of the sub-categories to emerge strongly in participants’ accounts was Business Priorities, where the financial concerns of the organisation influence the meaning and translation of recovery-orientated practice. It was suggested that the NHS business model is informed by competing government and commissioning priorities, and while policy provides overall directives to support recovery, there is a risk to organisation survival if funding and contractual objectives (which often seem to conflict

with promoting recovery) are not met. One senior manager stated: *'Recovery is indeed an institutional strategic priority, but it isn't the only one..., and the commissioners put numerous targets on us which very often are not about treating people as individuals.'* (Senior manager, psychologist)

5.2.3.i Organisational survival

Supporting recovery was predominantly viewed as an additional business objective that competes against a back-drop of meeting savings programmes, maintaining financial stability and meeting demands of increasing activity targets. The reality of managing and reorganising services on a constantly contracting trajectory over the next few years was identified as a difficulty.

'Recovery doesn't sit as some Utopian organisation, it sits within real organisations and all organisations across the country are having to reconfigure themselves to manage in this climate but I don't think that's helpful to somebody who's trying to recover.' (Senior manager, Psychologist)

Another senior manager reported: *'One thing is survival basically...there are worries about sustainability of all services because of the financial situation.'* (Senior manager, psychiatrist)

Staff acknowledged the challenges facing organisations in the current financial climate. Some viewed saving money, rather than supporting recovery, as the 'overarching vision of the service at the moment,' where recovery support is shaped to promote organisation survival. One team leader stated: *'I feel recovery has been hijacked as an agenda to save money and get people squeezed quickly out the services before they're well enough'* (Team leader, nurse, AOT).

A few staff participants described recovery support as keeping people out of hospital. Others suggested that services tailor recovery-orientated practice to meet commissioning demands such as employment outcomes.

'I'm not sure whether our idea of recovery is the same as our senior managers' idea of recovery... we get questionnaires all the time 'how many people have you got on your caseload that are in work, how many people have you got that you got jobs for?' (Nurse, CMHT)

5.2.3.ii Quality or quantity

Commissioning structures (such as mental health clusters, care pathways) were also considered incongruent with supporting recovery. The Payment by Results funding system was viewed as prescriptive and lacking individual choice and a person-centred approach, with organisational priorities taking precedence. A social worker stated: *'It has to be like that because of payment by results.'* *'But whose results, I think that's the thing.'* (Social worker, across teams)

One senior manager stated:

'There's a real tension that we are going down a route of care pathways and provision of care that's quite restricted. So people will get an assessment within a period of time, then they'll have interventions and there'll be an expectation of discharge, along a pathway.' (Senior manager, occupational therapist)

Participants identified that performance and compliance targets (such as caseload size, seven day follow-up) compete with recovery. Services are measured on increased activity and contact time targets, referral demands and not on service user experience. When asked to identify priorities for practice, one team leader stated: *'If you don't meet the targets then I'm usually chasing people, so for me it's more focused on making sure we meet performance targets, feeding the beast as it were.'* (Team leader, manager, CMHT)

The idea that recovery is supported and people are empowered to become more independent was considered incongruent with measuring how many times that person had been seen, or having to achieve a certain target to see that person.

'The thing about contacts is it's all about numbers, it's not anything to do with the quality of the work. So you've got to cram in this number. It's like you've only done two contacts that day, its quantity not quality isn't it.' (Social worker, EIS)

Staff appeared disappointed that the focus is on efficiency and productivity and not on quality of care, and identified that their work prioritised tick box exercises. The care programme approach was seen as an additional tick box target, which according to one worker *'becomes the priority rather than clients' needs'*.

'Sometimes things like care plan reviews are seen as more of a paper exercise, not as something that can really help with someone's recovery.' (Team leader, occupational therapist, CMHT)

Similarly, recovery was viewed as an additional practice task, often due to the volume of work, to be considered when all other targets are met. Some staff reported that *'If you haven't got your cases sorted and you don't know what you're doing, your risk assessment hasn't been done; recovery will go out the window.'* One team leader stated:

'You get a reductive approach in order to respond to the capacity issue really, and therefore recovery does get squeezed because as good as it needs to be or should be, you haven't got the time to put thirty five people a good recovery plan because there's only you...' (Team leader, nurse, CMHT)

Recovery was viewed by many participants as an outcome, for example where service end points are assessed by staff and based on professional judgement on when a person is ready for discharge.

'I think what has happened, in terms of Trust goals, recovery became synonymous with discharge, that 'oh, this person's recovered, therefore we'll discharge them' and I think there was a lot of cynicism at first, that 'oh this is gonna be used as a means that we get people out of the service and they've recovered, goodbye', rather than perhaps what it's supposed to mean.' (Team leader, nurse, CMHT)

In some instances recovery is measured in terms of service throughput or 'moving-on'. For example, in one NHS Trust *'there are targets in the service spec which says you should have made a significant recovery within two years'*.

There's a difficulty in, I adhere to a recovery model, but there's a balance between somebody who writes rules that says, 'Recovery will take two years.' Yeah, that's how long you've got to work with them. (Nurse, CMHT)

Some staff identified how service throughput is at odds with successful recovery support. One team leader reported: *'It's this using the recovery model to say, 'well, you know they're not motivated enough', or 'they're not taking responsibility' or 'they're not taking ownership and therefore we're stepping out because we're a recovery-based service.'* (Team leader, nurse, CMHT) However, few staff questioned: *'Is there a way that we can turn this around for people with a mental illness to say this is the limit of services? Therefore the driver for you to get well and stay well is ever stronger.'*

5.2.4 Sub-category: Staff Role Perception

The category Staff Role Perception encompasses how staff understand their work roles and how staff prioritise work tasks. Despite reported frustrations, a few workers identified an ability to support recovery outside organisational priorities and described

ways of balancing statutory demands and fulfilling service user priorities. A social worker stated: *'I was working till half six last night with someone and I'm a 9 to 5 worker but I sometimes work at eight in the morning, sometimes work at half six if it suits the client.'* (Social worker, CMHT)

A readiness to test the boundaries and break the rules emerged as an important factor for some. One team leader stated: *'I say to my team I really don't give a toss about those figures, if I know you are going out and you are knocking on employers doors...thinking well who will take up, that is a good use of your time and I will stand up and be counted against when they look at our numbers, that's what I think.'* (Team leader, nurse, AOT)

A staff participant reported:

'If somebody says to me that I need to have a patient discharged within six months, I'll break the rules, yeah. Cos if somebody still needs intervention, they still need intervention and all we're doing is setting them up to fail if we do these things too fast and as long as I feel that I'm justified in what I'm doing... it's about the patient, it's about what they need rather than what the big bods need.' (Nurse, CMHT)

Other participants felt they must comply within service parameters. One nurse described: *'I've got to function within that, otherwise I'm gonna lose my job and I can't afford to lose my job. I've got to function within the parameters set out by the bosses.'* (Nurse, CMHT)

Staff who felt they were able to support recovery within the organisational parameters prioritised person-centred and strengths-based practice and identified these approaches as paramount to their success.

'It's having that vision in mind all the time, so when you see somebody you're trying to build on their strengths and the sort of things that are working rather than thinking about things that get in the way of their recovery... trying to all the time play to their best strengths.' (Senior manager, psychiatrist)

While some staff illustrated their role in supporting recovery as having specialist knowledge, others recognised interactional elements and identified the need to understand that service users are people whose most interesting quality is not their illness, and who are not viewed as fundamentally different to themselves. Staff reported: *'I think the kind of core thing that achieves all that is the quality of the working*

relationship you have with the person. I think if you haven't got that, you won't achieve a whole lot.' One staff participant explained:

'To me I draw on things that have helped me and I have observed with my experiences with clients and I think its. What has helped me is listening to clients and not judging them and accepting them and not having a stigma about oh, we've seen it all the time...And to me, even in a relationship, if you see that someone hasn't got genuine something for you, don't have your best interest at heart, you don't go closer to them or you don't listen to them.' (Nurse, AOT)

Participants who prioritised the working relationship and who shared a bit of themselves with service users recognised the value for service users to also see staff as people. One team leader stated: *'You need that core value in a person, to work a certain way and to believe. I guess a humanist approach...we're all human and we're all people, and its people first kind of thing.'* (Team leader, nurse, CMHT)

Another staff participant stated:

'I suppose recovery for me is about understanding people that have mental health problems are me, you, anybody, and that people should be respected, and they should be encouraged to lead the lives that they want to lead.' (Support worker, CMHT)

5.2.4.i Personal values and qualities of staff

The understanding of those staff that identified an ability to support recovery outside organisational priorities was often influenced by personal values and professional maturity where traditional values and power relations are challenged. While some participants perceived social workers and occupational therapists to have more opportunities for recovery-orientated practice, the differences in practice could not be accounted for by profession. Equally, individual differences in practice could not be accounted for by years of experience.

There appeared to be greater relation to who you are; personality traits, professional confidence, and different conceptualisations that individual staff have of their sense of self and job role. A nurse explained: *'I think it's shaped by a few things, I don't think it's particularly profession based. I think it depends on you as an individual. I think some basic attitudes and values are there or they're not.'* (Nurse, CMHT) Another nurse stated: *'I think part of it's got to be about my own values. It has to be, I think. And I think that has been informed over the years by not liking the power imbalance, and, wanting to do more of, well, have a more collaborative relationship with people.'* (Nurse, CMHT)

A team leader reported:

'It's more about your belief system that's behind what you're doing I think than a lot of the time than what you're doing. I think then what you're actually doing, then is kind of more on top of it kind of thing, but if you have the right attitude from the beginning I think that things will just happen naturally. If you have a positive attitude towards working with service users to begin with and you think they can recover and you can give that person hope then that's the start of recovery really.' (Team leader, occupational therapist, EIS)

Staff attitude was also considered paramount. One nurse reported: *'I don't believe in dictating because it's not my life, I believe in enabling people to do it for themselves, because at the end of the day it's their lives and they have to function within it.'* (Nurse, CMHT)

5.2.4.ii Expectations of service users

Some participants expressed a need to challenge staff attitudes and to raise the expectations of people who live with mental illness.

'And I think the organisation can provide training and education for staff because I think there are lots of sort of attitudinal problems that people kind of perceive themselves as if you like, you know, they have moved on from working in an asylum but there's still that kind of attitude that the people they see and they see and they are caring for are patients under their care in this special setting rather than people who are on their way...on their...to some sort of recovery and just getting on with their lives in the community, so it's something about their expectations and their views about who they're seeing and what they're seeing and what they're doing with them and where they're going.' (Psychiatrist, CMHT)

Job value was also often presented as an influence on recovery orientation, for example, whether employment was considered a job or a vocation. Some staff focused on the esteem of their professional role, prioritising duty of care and professional identity, while others promoted empowerment and spoke of enabling service users to lead the lives they choose to lead.

'I think some people have very narrow ideas about what their job is and isn't about, a very narrow range of duties or tasks. The way I view it is that each person I'm working with, it's up for negotiation as to what the work will be.' (Nurse, CMHT)

Staff spoke about the impact of service disinvestment and reconfiguration on their work role, for example, managing in a climate of job uncertainty where posts are being lost.

'One thing I find unhelpful, it's difficult to engender optimism when we don't know ourselves what is going on and how things are changing and what the next plan is.' (Nurse, CMHT)

'If there are lots of changes or we don't know whether we're going to have jobs or jobs might change, then that creates a lot of uncertainty, and people sometimes think, well I'm not going to start anything because we don't know where we're going to be.' (Team leader, Nurse, CMHT)

Traditional power relations held in health systems also influenced how recovery support was translated. In one example, the people using services themselves were considered a barrier to recovery.

'Sometimes I think the service user gets in the way, because, we, a lot of the time because it's quite early on in their, they might not, want to engage with services. So we do have a core group of people who feel that what they experienced, they just want to get on with it and manage it themselves. And actually, some of those people aren't managing it very well and are quite socially isolated and stop taking their medication and therefore become unwell again.' (Occupational therapist, EIS)

Another participant stated: *'It's simply too unachievable almost to think about recovery because recovery is I suppose in some people's minds, getting over- it's like recovery from an infection...Yeah, basically it's a curative term and I think it's unrealistic to expect people to think that they can be cured...'* (Nurse, CMHT)

A team leader stated:

'It's not a concept that sits comfortably with my clientele, cause I think they would feel a bit, it would be a bit of an alien concept for them, I think recovery usually is... they would see it as, as being free of the illness, and I think that most of them are, are fairly aware, by the time they get to my tender care, that they are not going to be free of the illness, so it's not something that I talk about a lot.' (Team leader, nurse, CMHT)

Similarly, in another example, a worker identified illness as a barrier to recovery.

'Well I mean sometimes you meet people and they're just completely stuck and nothing you can do can unfree them. So someone's entrenched illness I guess. But even then I think you should never give up you have to just keep on trying different things.' (Psychologist, CMHT)

Few staff made reference to the involvement of people who use services in the planning of their own care or in the planning of services as a priority to enable recovery support. One worker noted the importance of staff support in empowering service users to have ownership of their recovery.

'But I don't think any of that is going to ever happen until we shift our thought processes from crisis management to giving more responsibility and giving

more I guess, a bigger voice to the service users. I think it's very much, us, giving it to them and I think [pause] yeah, I think until our, our, there's got to be a change in thought for any of that to ever come into it. [laughs]' (Occupational therapist, CMHT).

5.3 Discussion

This grounded theory study investigated staff perspectives on supporting recovery, with the goal of improving understanding about how staff support recovery in their practice, and what barriers and facilitators exist in providing recovery-orientated practice in mental health services (Strauss and Corbin, 1990). The study used symbolic interactionism and attempted to discover the processes that people use to make sense of their situations (Blumer, 1969). Individuals act reflexively with their environments in order to understand the world around them and to develop meaning in their lives. The findings will be discussed in context of the "sensemaking" process (Weick, 1995) which builds on the symbolic interactionist perspective to shape organisational structure and behaviour (Fine, 1993).

A core category of Competing Priorities was identified, describing how staff struggle to make sense of recovery-orientated practice in the face of conflicting demands and priorities. Three sub-categories describing the competing priorities for practice were identified: Health Process Priorities, Business Priorities and Staff Role Perception. Health Process Priorities involve clinical systems dictating the direction of practice. Business Priorities involve giving primacy to financial and organisational concerns. Staff Role Perception refers to the values and priorities of individual workers that shape their practice. The sense of competing priorities for practice appeared to lead to a conceptual uncertainty for staff of what recovery means in practice.

5.3.1 Implications for policy and practice

At the rhetorical level, staff participants indicated universal sign-up to providing recovery support in mental health practice. However, conceptual uncertainty of what recovery means for practice was evident. This finding is consistent with the critique of recovery as a "*polyvalent*" concept (Pilgrim, 2008) discussed in Chapter 2. This is also echoed in the findings of Piat and Lal (2012), where the challenge of '*conceptual uncertainty and consistency regarding the meaning of recovery*' was identified as a core influence on the success of implementing recovery-orientated practice (p.293).

Conceptual uncertainty influences implementation. There is evidence that lack of clarity can reduce the uptake of health innovations (Brooks et al., 2011). Furthermore, the

findings presented here identified a variety of competing priorities and demands for practice at different levels of the health system e.g. individual staff level, organisational level) (Damschroder et al., 2009), adding to the complexity of translating recovery support into practice. Studies of the implementation of health innovations indicate that workers actively navigate this complexity by using past experience, underlying values and environmental cues (i.e. interpreting organisational priorities) to begin to understand what recovery might mean in practice. The result of this sensemaking process determines how staff view the situations around them and subsequently influences the way they act and respond to the identified competing priorities (Weick, 1995). Greenhalgh and colleagues (2004) write: *'People are not passive recipients of innovations. Rather...they seek innovations, experiment with them, evaluate them, find (or fail to find) meaning in them, develop feelings (positive or negative) about them, challenge them, worry about them, complain about them, 'work around' them, gain experience with them, modify them to fit particular tasks, and try to improve or redesign them—often through dialogue with other users'* p.598 .

Sensemaking and recovery

Weick (1995) proposes that the concept of sensemaking is the central activity for staff within all organisations . The sensemaking process involves staff using past experience (e.g. practice guidance passing in and out of fashion, working with peer support workers etc), underlying values (personal, professional and/or organisational) and environmental cues (e.g. risk management, targets etc) to shape understanding. In this context, how staff make sense of recovery-orientated practice (e.g. as something hard to operationalise in the face of competing priorities) then plays a part in determining which cues are noticed as being important, and that will in turn affect how staff act in the future. In the case of the findings presented here, the strong emphasis on health process and business priorities reinforced the diverse meanings of recovery-orientated practice. In terms of the sensemaking process, if staff viewed recovery in terms of clinical recovery (discussed in Section 2.1), it could be argued that those involved would notice and interpret the related cues such as aspects of guidance that support clinical treatment. If those involved considered the clinical treatment successful, this view of what recovery means for practice is reinforced. Equally, service reorganisation (e.g. to support funding arrangements) such as the introduction of care pathways could be viewed as a positive change if staff considered that it provided clear standards of care to support recovery (Khandaker et al., 2013). If, however, recovery support is seen as a tool for partnership working and for promoting empowerment and choice, then staff might think about co-producing care plans with service users and work to the

goals of people who access services. Exposure to co-production practices that this would involve would then influence future beliefs of those involved about the nature of recovery in practice (Weick, 1995).

The influence of organisational climate (for example, shared perceptions of policies, procedures and practices) contributes to the sensemaking process (Handy, 1993, Checkland et al., 2009). The findings presented here suggest that health organisations function in a climate where the meaning of recovery support is modified to fit a health infrastructure organised around diagnosis, symptoms and risk. While support for recovery is evident in contractual arrangements (and has been used to measure service quality), it is one objective among many, and services define the concept flexibly to meet other health targets (Pilgrim, 2008). For example, successful recovery support has been operationalised in terms of improved clinical outcome scores, reduced risk, and return to employment (Warner, 2009).

The organisational culture (for example, shared beliefs on business ethics and social responsibility of the organisation) also influences how health innovations are understood (Piat and Lal, 2012, Farkas et al., 2008). The precedence given to health service business priorities impacts on practice, because financing and commissioning demands influence clinical decisions that affect value and quality of care (Slade et al., 2014). Organisations seek to improve value for money, typically through paying services by results which are measured as activity targets or service throughput such as discharge or reduced hospital admissions (Department of Health, 2012c, Department of Health and Human Services, 2003), rather than as personalised service user outcomes or experience of care. Rather than expecting service users to fit around service priorities, the need for services to be more responsive to people who use services has been identified (Department of Health, 2012b).

As reported in Section 2.3, Whitley and colleagues (2009) also identified innovative organisational culture as an instrumental influence when implementing the Illness Management and Recovery program (IMR) in the United States (Whitley et al., 2009). There is concern that recovery is translated to support service cuts or to exclude those individuals in most need of support where individuals are labelled as either recovered or not recovery-ready (Dickerson, 2006). Equally, the research presented here identified some organisations that have stipulated a time frame in which one should recover. For some recovery has simply become a new term for rehabilitation. Because the call for recovery-orientated services is happening alongside the current financial

climate, there is concern that recovery could be co-opted by the system, i.e. using a recovery label to meet organisational priorities rather than service user priorities (Roberts and Hollins, 2007). However, of interest to employers, a recent study identified that staff working in perceived recovery-orientated services reported lower levels of exhaustion and higher levels of professional accomplishment and job satisfaction (Kraus and Stein, 2013). This implies that workforce productivity may also be enhanced by an organisational culture that focuses on personal recovery.

Alongside staff experience, the process of sensemaking is also influenced by personality, intelligence and what is considered important and motivating. The link between personality and organisational behaviour (Avey et al., 2008), and the importance of the relationship between personality, Intelligence Quotient (IQ), and emotional intelligence have been highlighted (Furnham, 2008). Social intelligence is also a further consideration (Hogan, 2007).

Weick (1995) suggests that identity, that is, who individual staff think they are in their context, is central to shaping how they interpret cues and act. However, the degree to which individual staff participants focused their practice on personal recovery seemed to vary in relation to personality traits and personal values, as well as professional confidence and different conceptualisations that individual staff have of their sense of self and job role. Cleary and colleagues (2014) argue that the professional quality of humility provides an important means by which genuine and meaningful collaboration between staff and individuals living with mental illness can be achieved (Cleary et al., 2014). The importance of personal characteristics might point to the need to consider workforce recruitment strategies which focus not only on competencies (O'Hagan, 2001, Russinova et al., 2011, Stuber et al., 2014) and practice standards (Davidson et al., 2009b) but also on personality. For example, research might investigate which personality trait(s) (e.g. from the Big 5 trait clusters: openness, conscientiousness, extraversion, agreeableness and neuroticism) (McCrae and Costa, 2002) are more likely to (a) be recovery-supporting and (b) help services retain a focus on personal rather than service-defined recovery. With this information, and to counterbalance the tension between meeting organisational targets and supporting the priorities of service users, the values and attitudes of future employees might be considered during workforce recruitment (Furnham, 2008, Prytys et al., 2011). This suggestion may carry controversy and discordance with employers; the current need for organisational survival suggests that staff are required to focus on health and business priorities.

Staff participants who prioritised the working relationship and who identified an ability to support recovery outside health process and business priorities appeared to have greater awareness of themselves and the ability to reflect on their job role. They appeared to value their interaction role and identified interaction as a core therapeutic skill. Other staff participants saw their role tied more strictly to procedural concerns, where they held specialist knowledge, and the focus of practice was the illness and not the person. Some participants identified conflict, and saw the worker's role as strictly guided by the organisation (for example, where commissioning targets view interaction as peripheral and not central to practice). Hogan (2007) notes, *'Mature organisations have so many rules that most innovations will require breaking a rule, unless provisions are made for this'* (p.90).

Promoting lived experience as a recovery resource

The conceptual framework of recovery-orientated practice (reported in Chapter 3) identified four practice domains: promoting citizenship, organisational commitment, supporting a personally-defined recovery and working relationship. The staff participant accounts presented here made reference in part to the domains of promoting citizenship, supporting a personally-defined recovery and organisational commitment. However, although the conceptual framework of recovery-orientated practice identified the need for practitioners to support individuals to be partners in their own care, the findings presented here identified little reference to either the expectations of people using services, or to using the "lived experience" of people using services as a recovery resource. Staff conceptualisations of recovery-orientated practice consistently under-emphasised the role of service users as active partners. This reinforces the critique that recovery, as it has been incorporated into mental health systems, has been changed to fit the dominant medical model (Beresford, 2010) and to avoid addressing the central institutional issues of power and control (De Cremer et al., 2012). Interestingly, the concept of 'new professionalism' calls for an increased focus on relationships and collaboration with people who use mental health services (Bhugra and Malik, 2011).

Parallels can be drawn with service user perspectives on supporting recovery. For example, the recovery concept, initially a service user defined phenomena, is itself made up of multiple and often contested meanings (Leamy et al., 2011). Service users report that recovery has become *"hijacked"*, where they too have competing expectations placed on them (p.30) (Mental Health 'Recovery' study working group, 2009). People with lived experience have also reported a feeling of lack of

individualisation, a focus on organisational goals rather than hopes and dreams for their own view of a meaningful life, and a difficulty of working in partnership (Braslow, 2013).

5.3.2 Strengths and limitations

A strength of the study was the methodologically rigorous application of grounded theory (Strauss and Corbin, 1990), a highly iterative process that followed the concerns of participants. Use of the symbolic interactionist approach enabled the researcher to explore data across personal, social and environmental influences. Reflecting on the three core assumptions of symbolic interactionism (Blumer, 1969) that guided this study, the findings suggest that: at the personal level, 1) staff participants have their own personal perspective of recovery-orientated practice (i.e. staff role perception); at the social level, 2) the notion of recovery as applied to practice is influenced and directly shaped through priorities of the health system, most notably from commissioners and senior managers (i.e. business priorities); and at the environmental level, 3) recovery-orientated practice continues to be modified through experience and the environment within which staff work (i.e. health process priorities). Competing priorities (informed through social interaction with commissioners, senior managers, team leaders, colleagues, and service users) shape staff understandings of recovery-orientated practice and influence the success of recovery support.

Further strengths were the geographical and professional diversity of the sampling frame, and that data collection and analysis continued until theoretical saturation was reached. The accounts of 97 members of staff (with diverse job roles) were explored, making the sample large for a rigorous qualitative study. Participants were recruited from 51 CMHTs across five NHS mental health Trust sites using purposive and theoretical sampling strategies. Nursing staff made up the majority of the sample as they comprise the majority of the workforce. Staff working in adult community mental health teams (CMHTs) (sometimes called Support and Recovery or Rehabilitation teams) made up two thirds of the sample and staff working in assertive outreach, early intervention and forensic teams made up one third of the sample to provide a CMHT spread representative of service provision.

The findings are specific to the study context, that is five NHS mental health Trusts, from 2010 to 2012. Having installed rigour throughout the research process, transferability to other similar contexts can be assumed (Whittemore et al., 2001). To enhance credibility, that is the trustworthiness of the findings, the emerging findings

were consistently and systematically checked with further data collection (for example, the interview schedule was iteratively revised to reflect and test the emerging findings) in line with grounded theory methodology. The author's views and insights regarding recovery support and working in NHS community mental health services were also explored to acknowledge how they might affect the inquiry. However, the grounded theory study did focus on mental health service community care provision and did not directly address staff perspectives on recovery as applied to in-patient care. For this reason, the developed theory is considered a substantive one because it developed *'from the study of [a] phenomenon situated in a particular situational context'* (p.174) (Strauss and Corbin, 1990). In contrast, a grand theory is generated from exploring a phenomenon in a variety of contexts.

The limitations of the study include use of a pre-defined recovery-orientated practice framework in early focus groups. Although efforts were made to encourage individuals' own conceptualisations, the conceptual framework may have influenced the descriptions of recovery-orientated practice provided by participants. While researcher reflexivity was used throughout, researcher interpretation is evident. The pros and cons of having worked in a role similar to that under study, and sharing a staff perspective, were explored in reflective diaries. The consolidated criteria for reporting qualitative research (COREQ) guideline was used to ensure quality when reporting the research in this chapter (Tong et al., 2007) and is included in Appendix 3. Only one COREQ item is not reported: the number of people who were approached but refused to participate or dropped out were not consistently recorded. Unfortunately, this was not practicable across all five NHS Trust sites. Additional data collection methods, for example participant observation, could have been used to gain closer and more intimate familiarity with the daily practice of staff participants and would have provided rich insights into staff social interactions. The opportunity to observe situations described by participants and the direct contact with recovery-orientated practice would have complemented the narrative from interviews (Cresswell, 1998). Participant observation was not feasible in terms of the practicalities of fitting a research project into an existing programme of research, but is a method for future consideration in terms of extending the research.

5.3.3 Conclusion and implications for the thesis

The findings of the grounded theory are clinically important, relevant to current health priorities, and have the potential to influence the mental health system at both policy and practice levels. While mental health staff are encouraged to transform their

practice towards a recovery orientation, they reported the need to manage competing health process and business priorities, which compromised their ability to make sense of, and support personal recovery. The findings point to the need for organisational alignment around a shared focus on recovery support, including how recovery support is conceptualised in practice.

Conceptual clarity is a significant factor influencing the success of recovery support. Chapter 6 builds on the need to reduce conceptual uncertainty and provides a broader context to the grounded theory findings by reporting a systematic review and narrative synthesis of staff understanding of recovery as applied to practice.

Chapter 6. Staff Understanding: Service-defined Recovery

Chapter 6 presents a systematic review and narrative synthesis of staff understanding of recovery-orientated practice, undertaken in the light of findings from a grounded theory study (reported in Chapters 4 and 5). The aim of the review was to synthesise primary research investigating staff and manager understanding of recovery-orientated practice in mental health services, using the grounded theory as a framework for analysis. Grounded theory methodology traditionally suggests that literature is synthesised after data analysis to ensure both that the developed theory is grounded in the data, and that the data are approached without assumptions from existing research (Strauss & Corbin 1990).

The Enhancing Transparency in Reporting the synthesis of Qualitative research (ENTREQ) guideline was used to ensure quality when reporting the research and shaped the structure of this chapter. The ENTREQ is a 21 item quality checklist developed for use when reporting a synthesis of qualitative research (Tong et al., 2012), included in Appendix 16.

Chapter 6 comprises four sections. The study rationale is outlined in Section 6.1, along with the background and aims. Section 6.2 outlines the method used to conduct the systematic review. Section 6.3 reports the findings. Finally, the implications for practice are discussed in Section 6.4.

The systematic review has been published (Le Boutillier et al., 2015a), and is included in Appendix 21.

6.1 The rationale for a systematic review and narrative synthesis

Following the development of a grounded theory (reported in Chapters 4 and 5), a systematic review and narrative synthesis was conducted to better understand the Competing priorities, to extend the conceptual clarity of staff understanding of recovery-orientated practice, and to place the theory in the context of wider literature. While conducting a systematic review in the context of grounded theory methodology is not considered necessary (Strauss and Corbin, 1990), the decision to conduct a systematic review and synthesis of all available evidence was made for a number of reasons. First, the need for a review that built on the grounded theory study was

identified to answer the question of how staff understand recovery as applied to their practice. Second, early scoping searches identified few existing studies on staff understanding of recovery-orientated practice, therefore using systematic procedures to identify all available evidence was considered necessary. Third, the transparency that systematic review methodology affords was considered an asset in terms of identifying and using the included studies data to contextualise the grounded theory (Grant and Booth, 2009).

Narrative synthesis is an approach to both the systematic review and the synthesis of findings (Popay et al., 2006). It was used here because like grounded theory methodology, it is a systematic and transparent approach, and is appropriate for use with diverse evidence. The fit between narrative synthesis and grounded theory methodology seemed a natural one, with the first stage of narrative synthesis being to develop a theory to inform the review question and search strategy. Indeed, the developed grounded theory (reported in Chapter 5) can be seen as constituting the first step for narrative synthesis. Grounded theory methodology was not used in the systematic review because the focus was on using evidence to contextualise an existing theory rather than to generate a new one. Evidence synthesis in grounded theory is inductive and allows themes to emerge rather than being deductive with the use of a pre-defined framework (Weed, 2005).

6.1.1 Aim

The aim of this study was to conduct a systematic review and narrative synthesis of primary research investigating how clinicians and managers understand recovery-orientated practice in mental health services. The aim of narrative synthesis is to provide results that go beyond a description of the primary studies and provide a new interpretation and/or development of a new construct.

6.2 Method

The review question was *How do clinicians and managers understand the concept of recovery as applied to their practice?*

The protocol for the review was pre-registered in PROSPERO, an international database of prospectively registered systematic reviews in health and social care (PROSPERO 2013:CRD42013005942). The aim of this database is to reduce search bias and to enhance transparency.

6.2.1 Eligibility Criteria

Staff conceptualisations of recovery-orientated practice were sought. Where combined stakeholder conceptualisations of recovery-orientated practice were reported (and not analysed as a sub-group), such as clinician and service user, studies where staff made up at least 50% of participants were included. Original conceptualisations of recovery as applied to practice were sought so studies measuring recovery knowledge using pre-defined conceptualisations were excluded. Only English language articles available in printed or downloadable format were included.

Participant inclusion criteria were clinicians and managers, defined as staff from any profession (whether paid or voluntary) who provide or manage mental health services, in primary, secondary or tertiary care. Interventions were explicitly referred to as recovery-orientated practice. Those typically aligned with recovery e.g. person-centred planning were only included if identified as recovery-orientated practice. Outcomes were expressed knowledge or attitudes about recovery-orientated practice, or self-reported or observed recovery-orientated behaviour. Finally, study design comprised empirical primary research papers that utilised established quantitative or qualitative research methodology (e.g. questionnaire, survey, interviews, focus groups), with a minimum sample size of three participants. Opinion pieces and editorials were therefore excluded.

Studies were excluded if they focused on recovery support in specialist mental health services (e.g. substance misuse, eating disorder) or patient-led organisations (e.g. recovery centers, clubhouse).

6.2.2 Search strategy and data sources

Due to the complexity of the search area, sequential scoping searches (n=5) were conducted to test and finalise search terms. The initial search strategy was identified following a review of six pre-selected marker papers, chosen based on expert review of the field. Table 6.1 details the marker papers.

	Full reference
1	Gilbert H, Slade M, Bird V, Oduola S & Craig TKJ (2013) Promoting recovery-oriented practice in mental health services: a quasi-experimental mixed-methods study. <i>BMC Psychiatry</i> , 13, 167.
2	Aston V & Coffey M (2012) Recovery: what mental health nurses and service users say about the concept of recovery. <i>Journal of Psychiatric and Mental Health Nursing</i> , 19, 257-263.
3	Cleary M, Horsfall J, O'Hara-Aarons M & Hunt GE (2013) Mental health nurses' views of recovery within an acute setting. <i>International Journal of Mental Health Nursing</i> , 22, 205-212.
4	Hungerford C & Kench P (2013) The perceptions of health professionals of the implementation of Recovery-oriented health services: a case study analysis. <i>Journal of Mental Health Training, Education and Practice</i> , 8 (4), 208-218.
5	Rogers JA, Vergare MJ, Baron RC & Salzer MS (2007) Barriers to Recovery and Recommendations for Change: The Pennsylvania Consensus Conference on Psychiatry's Role. <i>Psychiatric Services</i> , 58 (8), 1119-1123.
6	Piat M & Lal S (2012) Service Providers' Experiences and Perspectives on Recovery-oriented Mental Health System Reform <i>Psychiatric Rehabilitation Journal</i> , 35 (4), 289-296.

Table 6.1: Systematic review marker papers (n=6)

These marker papers were chosen to span a range of study designs and professional groups. The sensitivity of the resulting search was tested by assessing whether the references retrieved from the search included the marker papers.

Initial scoping searches were completed using three databases (PsycINFO, Medline, CINAHL) to test and narrow the key words and Medical Subject Heading (MeSH) terms. The initial search included broad search terms (for example, diagnosis specific terms) and produced 8,231 hits which was not considered feasible given the number of databases to be included in the search.

MeSH terms (thesaurus of terms used for indexing articles) were used to broaden the search and to enhance the sensitivity of the search. Initial search terms were refined and modified to optimise the balance between specificity and sensitivity. For example, specificity was increased by using terms for specific professional groups to define staff, balanced with the sensitivity of the use of the term 'recovery'. The concepts of 'understanding' and 'applied to practice' were also combined to increase sensitivity, as when split, few marker papers (n=2) were retrieved. Limits were also placed on the protocol to ensure feasibility.

The final protocol comprised search terms identified in the title, abstract, keywords and MeSH terms. The search strategy was designed in OVID, and is shown in Table 6.2. The strategy was modified for EBSCOhost and PROQUEST.

	Search Terms (free text terms) identified in the title, abstract or keywords (subject headings specific to each database included in Appendix 17).	Concept
1	"mental illness" OR "mental disorder" OR "mental disease" OR "mental health" OR mental adj2 problem\$ OR psychol\$ adj2 (health or problem\$ or disorder\$ or illness\$) OR psychiatr\$ adj2 (health or illness\$ or disorder\$ or problem\$ or disabilit\$)	All mental illness (not diagnosis specific)
2	'recover\$'	Recovery (truncated terms covering recovery orientation, recovery promotion, recovery support etc)
3	Staff OR worker\$ OR "care coordinator\$" OR personnel OR employee\$ OR clinician\$ OR professional\$ OR practitioner\$ OR provider\$ OR leader\$ OR manager\$ OR physician\$ OR psychiatrist\$ OR doctor\$ OR nurse\$ OR "occupational therapist\$" OR "social work\$" OR psychologi\$ OR "peer support\$" OR "vocational specialist\$" OR volunteer\$ OR student\$ OR "decision maker\$"	Staff
4	mean\$ OR define\$ OR comprehen\$ OR opinion\$ OR view\$ OR belief\$ OR knowledge\$ OR perspective\$ OR attitude\$ OR discourse\$ OR theor\$ OR experience\$ OR perception\$ OR rhetoric OR awareness OR translat\$ OR implement\$ OR operationali\$ OR philosoph\$ OR appl\$ OR understand\$ OR conceptuali\$ OR interpret\$ OR value\$ OR behavio\$	Understanding and Applied to practice
5	1 AND 2 AND 3 AND 4	
6	Limit to English Language AND Remove duplicates	

Table 6.2: Final search strategy

Six data sources were used:

1. Electronic databases searched from inception until 17 November 2013: PsycINFO, MEDLINE, EMBASE, Cumulative Index of Nursing and Applied Health Literature (CINAHL), British Nursing Index, International Bibliography of Social Science (IBSS), Applied Social Sciences index and Abstracts (ASSiA), and Scopus.
2. The table of contents from inception until 17 November 2013 were hand searched from Psychiatric Rehabilitation Journal, Psychiatric Services, Journal of Psychiatric and Mental Health Nursing, Administration and Policy in Mental Health and Australian e-journal for Advancement of Mental Health. These journals were chosen because they were identified (e.g. in database search) as having published research specific to staff perspectives on recovery-orientated practice.
3. An internet search using Google Scholar (scholar.google.co.uk) was conducted using the search terms 'staff', 'mental health' and 'recovery' to identify grey literature of publishable quality. The first 100 entries were reviewed on 10 February 2014.
4. Expert consultation involving 13 mental health service users, professionals, academics, and researchers.
5. Reference lists of included articles were hand searched for additional papers.
6. Articles citing included studies were searched using Web of Science (wok.mimas.ac.uk).

6.2.3 Data extraction

Duplicates were removed in Endnote, Version 6 (Thomson Reuters). Titles identified in the electronic search were read, to identify those with possible relevance. Abstracts from relevant publications were reviewed, and where they appeared to meet the inclusion criteria the full publication was obtained and assessed for eligibility.

One protocol deviation was made following retrieval of full text papers, where the decision was made to exclude studies focusing on the attitudes, knowledge or behaviour of students in professional training. The focus of the review was tightened to focus on the understanding of recovery-orientation of mental health professionals in their day-to-day practice. Information was received from three authors (e.g. giving further information about the sample) before deciding on inclusion.

All full text papers were independently double-rated for inclusion by the author and a researcher (with an academic psychology background). Reasons for exclusion were

recorded on an eligibility checklist, and disagreements were resolved through discussion or by a third rater, also with an academic psychology background. Additional quality assurance processes are outlined in Section 6.3 titled 'Assessing the robustness of the synthesis'.

6.2.4 Quality assessment

All included studies were qualitative, so quality was assessed using an established framework for assessing qualitative research evidence (Spencer et al., 2003). The quality framework covers the different stages and processes within qualitative enquiry, and the contribution, defensibility, rigour and credibility of the study. The author and a researcher (with an academic psychology background) double-rated the quality of all included studies. A quantitative score was calculated using the quality framework. Each of the 18 items are weighted equally and is rated 'yes' (allocated 1 point) or 'no' (allocated 0 points), giving a maximum quality rating of 18. The studies were divided into three groups; high quality was defined as a score of 13 or more, medium quality papers scoring 7 to 12, and low quality papers scoring 6 or less. Consensus between raters was required, with differences in opinion on three of the 22 papers resolved through discussion.

Quality assessment was not used to exclude papers due to the debate about whether quality checklists rate the quality of the study or the quality of reporting (Silverman, 2004). For example, papers describing brief reports, preliminary findings and mixed methods studies (often compromised by word count) were among the lowest checklist quality rating. Instead, quality rating was used for sensitivity testing. For example, similarities and differences in results were explored across high quality studies as well as across all studies (high, medium and low quality papers).

6.2.5 Analysis

Narrative synthesis was used to analyse the data (Popay et al., 2006). There are four elements in the narrative synthesis process: developing a theory; developing a preliminary synthesis; exploring relationships in the data, and assessing the robustness of the synthesis. The aims of each element are:

1. Develop a theory: To inform decisions about the review question and what type of studies to review, to contribute to the interpretation of the review's findings and to assess the applicability of those findings.
2. Develop a preliminary synthesis: To develop an initial description of findings from included studies

3. Explore relationships in the data: To consider differences within and between the data of included studies.
4. Assess the robustness of the synthesis: To provide an assessment of the strength of the evidence for drawing conclusions and for generalising the findings of the synthesis.

Figure 6.1 illustrates the analysis process and the chosen tools and techniques used to generate the narrative synthesis.

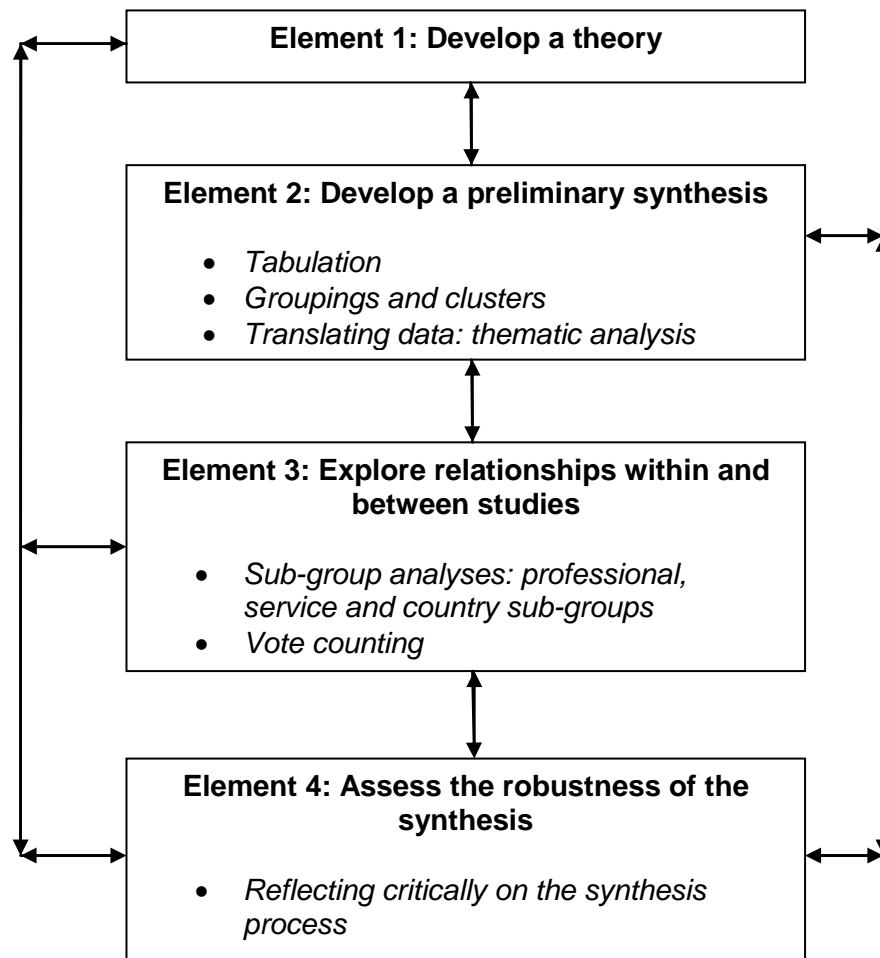


Figure 6.1: Narrative synthesis process

Popay and colleagues (2006) provide a selection of analysis tools and techniques for each element of the narrative synthesis process (Popay et al., 2006). Tools were chosen based on their suitability for use in the review of qualitative data. For example, a developed theory shaped the research question and search strategy, tabulated data provided a preliminary description of the different studies based on key characteristics such as country, study, method etc., and groupings and clusters allowed studies to be arranged according to characteristic similarities assumed to most closely relate to the

developed theory. All included studies were qualitative, so thematic analysis was used to systematically identify themes (based on the review question) across all studies.

While guidance outlines four distinct elements of narrative synthesis, developing an evidence synthesis is an iterative and non-linear process.

Element 1: Develop a theory

A theory is generally developed before synthesis begins, with the aim of the synthesis being to test the limits of theory. The theory was developed using grounded theory methodology (presented in Chapter 5).

Element 2: Develop a preliminary synthesis

Two approaches were used to provide an initial description of findings from included studies: tabulation and thematic analysis. For each included paper, the following data were extracted: country, service setting, staff group, design, and staff sample size. Two analysts (the author and a researcher with a background in academic psychology) independently conducted this tabulation, and compared coding decisions to maximise reliability. Disagreements were resolved by discussion. The key terms and components of the described conceptualisation of recovery-orientated practice were then extracted for thematic analysis. The predefined theory (Element 1) was based on an English sample, so studies conducted in the UK were used to identify initial categories, and then studies from other countries were grouped and analysed. Studies conducted in Europe, Australia and New Zealand, Canada and USA, and Hong Kong and Thailand were grouped and analysed in this order based on perceived relevance of study findings to the English context. To identify main categories and sub-categories, relevant extracts from each text were collated and grouped using a line-by-line approach. An initial deductive coding approach was undertaken whereby categories and sub-categories were mapped onto the stage one developed theory. Each category included in the deductive framework was defined to assist consistency of coding between the same two analysts. Alongside, an inductive open coding approach was also undertaken to identify new categories. Categories were constantly checked against the original data to ensure fidelity to the data-driven approach. Analysis was undertaken using NVivo QSR qualitative analysis software, Version 10 (QSR International Pty Ltd, 2012). In line with narrative synthesis guidance, themes were coded at the descriptive level with little attempt to infer beyond the surface or explicit meaning of the text.

Element 3: Explore relationships in the data

Vote counting was conducted to identify relationships within and between characteristics of each study, including a sub-group analysis by country, profession and health care setting. Thematic vote counting was also conducted using codes and the pre-defined conceptual framework of recovery-orientated practice reported in Chapter 3.

Element 4: Assess the robustness of the synthesis

An assessment of the strength of the evidence for drawing conclusions and for generalising the findings was achieved through the use of critical appraisal and by placing the findings in the context of wider literature.

6.3 Results**6.3.1 Literature search flow diagram**

The PRISMA flow diagram (Moher et al., 2009) is shown in Figure 6.2.

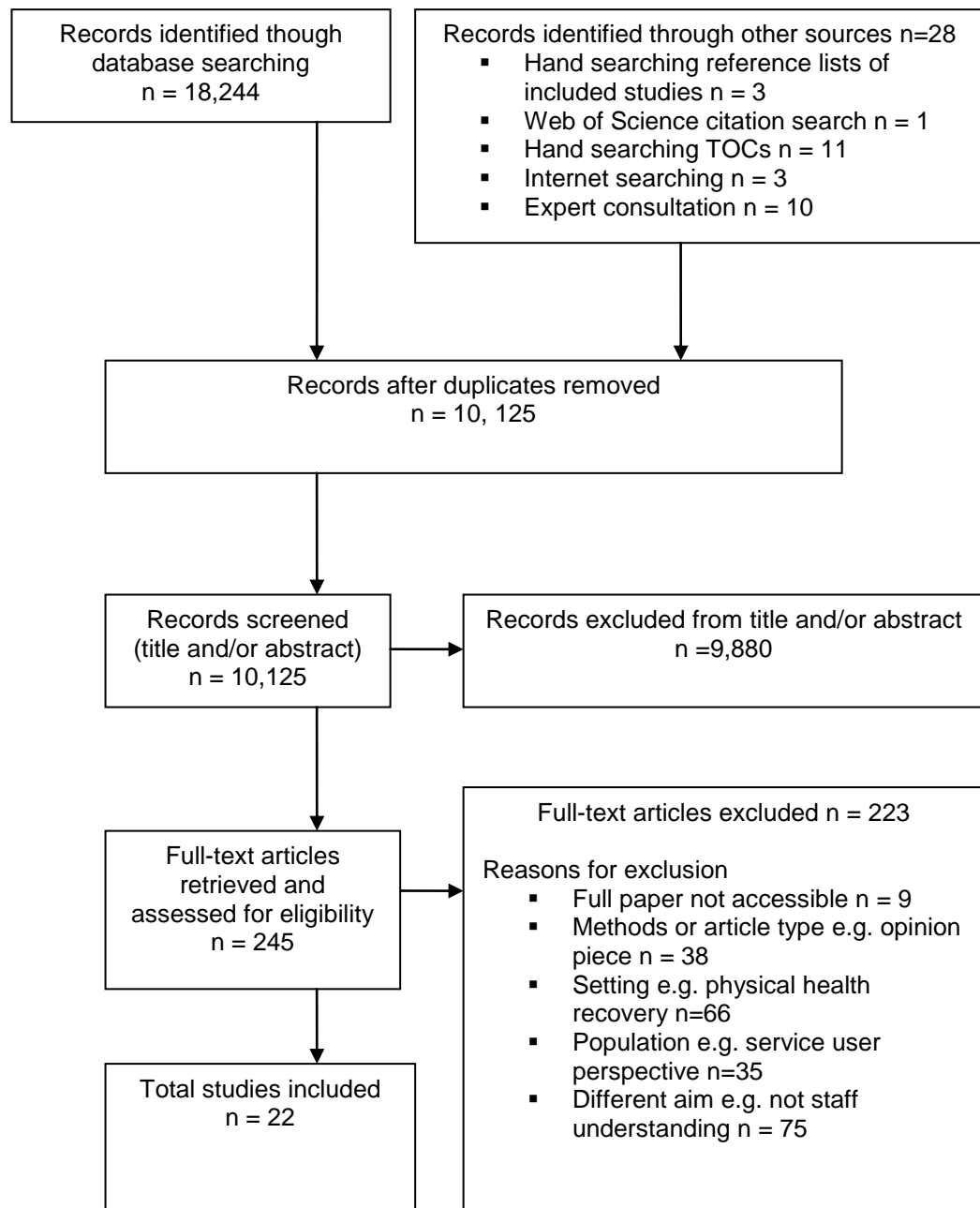


Figure 6.2 Literature search flow diagram

The included studies (n=22) are listed in Appendix 18. The number of publications matching the search criteria for each electronic data source are shown in Table 6.3.

Database	Brief Description	Search engine	Website	Dates searched	Records found
Medline & Medline In Process & Other Non-Indexed Citations	Biomedical research	OvidSP	http://ovidsp.uk.ovid.com/	1946 to November 11, 2013	3,339
PsycINFO	Psychology research	OvidSP	http://ovidsp.uk.ovid.com/	1806 to November week 1 2013	3,691
Embase + Embase Classic	Biomedical and pharmacological research	OvidSP	http://ovidsp.uk.ovid.com/	1947 to November week 1 2013	3,666
Scopus	Science, technology, medicine and social sciences research	Scopus	http://www.scopus.com/	1996 to present (unspecified)	4,775
International Bibliography of the Social Sciences (IBSS)	Social Science and interdisciplinary research	ProQuest	http://search.proquest.com/	1951 to present (unspecified)	222
British Nursing Index	Nursing and midwifery research	ProQuest	http://search.proquest.com/	1994 to present (unspecified)	332
Applied Social Sciences Index and Abstracts (ASSIA)	Health, social services, psychology, sociology, economics, politics, race relations and education research	ProQuest	http://search.proquest.com/	1987 to present (unspecified)	829
Cumulative Index of Nursing and Applied Health Literature (CINAHL)	Nursing and allied health literature	EBSCOhost	http://search.ebscohost.com	1981 to present (unspecified)	1,390

Table 6.3: Number of publications (n=18,244) matching the search criteria for each electronic data source (n=8)

6.3.2 Developed theory

The developed theory was presented in full detail in Chapter 5. In summary, conceptual clarity and staff understanding of recovery-orientated practice is a significant factor influencing the success of staff support for recovery, and the theory identified multiple understandings of recovery-orientated practice. Staff struggled to make sense of recovery-orientated practice in the face of conflicting demands, informed by competing priorities of different health system levels. Three sub-categories illustrating the competing priorities were identified: Health Process Priorities, Business Priorities and Staff Role Perception. The Health Process Priorities category linked with the concept of clinical recovery, and reflected traditional mental health concerns, including a focus on symptomatology and functioning, and the evidence-based medicine view of scientific knowledge. The Business Priorities category highlighted how financial and organisational priorities influence practice, viewing recovery as a service outcome, with potential trade-offs between quality and quantity. The final category, Staff Role Perception, captured staff views of their role and individual priorities in supporting recovery, which ranged from a custodial orientation to a recovery-orientated model of care, with a corresponding focus of practice from narrow (primarily symptomatology) to a more holistic emphasis.

6.3.3 Preliminary synthesis and tabulation

All 22 papers included in the review were qualitative or mixed methods studies (incorporating a qualitative component) reporting a staff conceptualisation of recovery-orientated practice. The total number of participants was 1,163. Study designs comprised interview (n=10), focus group (n=6), interview and focus group (n=2), participant observation (n=1), Delphi consultation (n=1) and mixed method (n=2) study designs. Studies involved nurses (n=3), case managers (n=3), social workers (n=2), psychiatrists (n=2), team leaders (n=1), occupational therapists (n=1), clinical psychologists (n=1), art therapists (n=1) and multidisciplinary samples (n=8). Service settings were in-patient (n=5), community (n=8), both (n=7) or not specified (n=2). Research took place in USA (n=7), Australia (n=4), Canada (n=4), UK (n=3), Europe-wide (n=1), Hong Kong (n=1) and Thailand (n=1). The included studies data extraction table is available in Appendix 19. Main details on the study including author, date, study design, method, participants and main findings were recorded.

Thematic Analysis

The thematic analysis of the UK and Europe-wide papers (n=4) led to an initial framework with one overarching category, called Staff Role Perception. Staff conceptualisations of recovery-orientated practice fell into three sub-categories: Clinical Recovery; Personal Recovery; and Service-defined Recovery. These sub-categories were then developed and extended further using the 18 studies conducted outside Europe. No further categories were identified, suggesting the developed theory is not specific to the English context. The coding framework (overarching category and sub-categories) is illustrated in Figure 6.3. The full coding framework is detailed in Appendix 20.

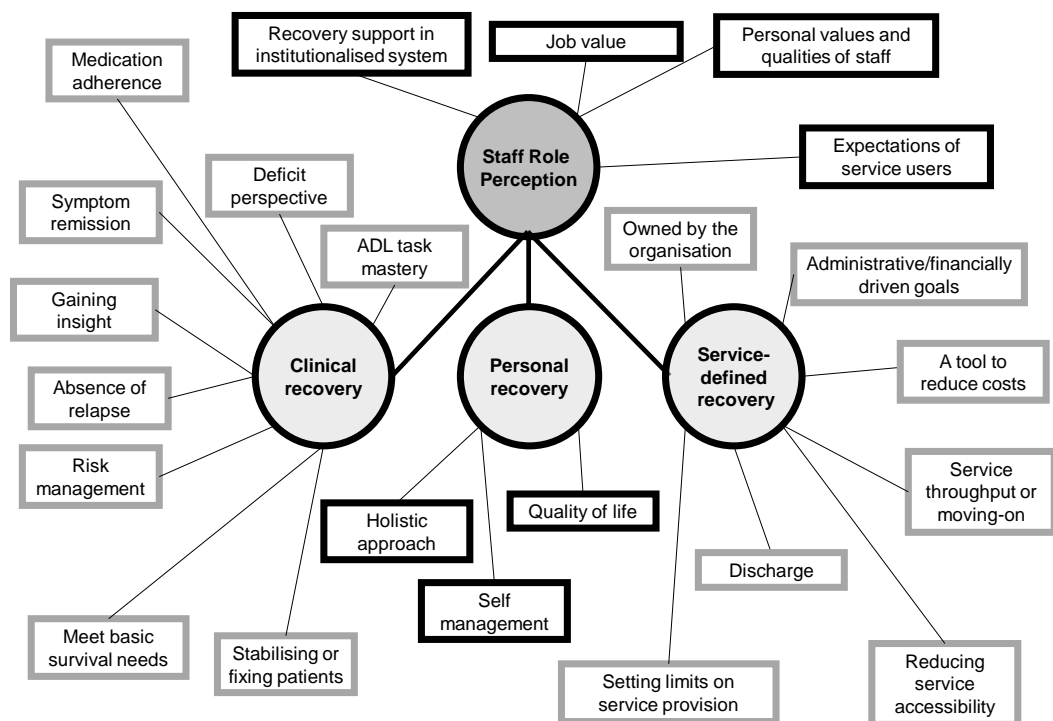


Figure 6.3 Staff conceptualisations of recovery-orientated practice

The overarching category and three sub-categories of recovery-orientated practice are now considered in detail.

Overarching category: Staff Role Perception

There are differences in how staff perceive their role in supporting recovery. Nine papers identified conceptual uncertainty, and two papers reported that recovery-orientated practice is a *"difficult to define"* concept (p.257/p.78) (Aston and Coffey, 2012, Ng et al., 2008). Aston and Coffey (2012) found that *'all participants had difficulty in articulating what recovery meant to them and its application to mental health'* (p.259). It was therefore no surprise that *'there is still considerable confusion about what mental health systems and psychiatrists should be achieving in a recovery-oriented system'* (p.1122) (Rogers et al., 2007). Other authors wrote:

'Providers expressed support of the philosophical tenets of recovery, but seemed unsure of how to operationalize recovery in a meaningful way' (Rice, 2009). One participant stated: *'But these women are struggling to keep their head above water, get basic stuff done. Recovery can seem almost like an unattainable goal, that doesn't have a lot of meaning'* p.314 (Rice, 2009).

Another participant stated: *'There were comments that there is no theoretical base in the recovery approach, it is an approach it is not a model, there is no clear definition of recovery or there are several definitions'* p.5 (Gilburt et al., 2013).

Some staff were confused by their role due to the uncertainty of what recovery means in practice:

'Given the multiple models of recovery from mental illness, providers were perplexed by what exactly was expected of them as publicly funded caregivers, as well as of the consumers they serve. Did recovery represent an outcome or a process?' p.110 (Watson et al., 2011).

In other words, *'the rhetoric of "recovery" was being used in services without clear understanding'* p.103 (Tickle et al., 2014), with the suggestion that *'many practitioners had "jumped on the bandwagon" without fully exploring what recovery means for practice'* p.9 (Courtney and Moulding, 2013).

Other studies found that recovery-orientated practice is not a new concept for staff:

'Other participants argued that recovery-oriented reforms within their

organizational contexts did not contribute anything new to their practice. They emphasized that that they were already implementing recovery long before it became a politicized concept. They characterized the term recovery as a “buzz word” or “fad” in mental health discourse, and a re-invention of what already existed.’ (p.292) (Piat and Lal, 2012).

Other participants stated: *“It’s just what clinicians do”, “It just feels like common sense at times”*. p.33 (Cone and Wilson, 2012).

The need for a shared understanding of recovery-orientated practice was identified:

‘It is evident, however, that there is more than one understanding of recovery, that these are sometimes idiosyncratic and that accomplishing a form of shared understanding is crucial to achieving mental health service-facilitated recovery’ p.259 (Aston and Coffey, 2012).

Three sub-categories were identified with a continuum of staff role perceptions ranging from a custodial orientation to a more holistic model of care, with a corresponding focus of practice from narrow (primarily symptomatology) to a more contextual hopeful emphasis. Service-defined views (whereby business priorities shape practice) were also identified.

Sub-category 1: Clinical Recovery

The Clinical Recovery category focused on a deficit perspective where mental state is improved or stabilised using medication and risk management interventions. Clinical recovery was measured by symptom remission, insight gain, absence of relapse and mastery in activities of daily living (ADL). The focus was on the professional as an expert working within an established health infrastructure, with clinical tasks shaping recovery-orientated practice.

‘Nurses viewed recovery from schizophrenia as involving symptom stabilization and the restoration of psychosocial functioning. Their views of recovery were characterized by a focus on clinical and functional improvement, such as symptom remission, an ability to carry out daily living activities, and a return to work or study’ p.325 (Kaewprom et al., 2011).

The power of the psychiatrist in assessing the patient to be relapse-free was noted in study participant quotes:

“I must assess how long a patient can remain relapse-free before I can declare my patient as having recovered.”

"A perfect recovery should imply no relapse."

"If we cannot guarantee absence of relapse in the next 30 years, how can we say a patient has recovered?"

"We have to assess how long a patient can remain relapse-free before we can define the patient as having recovered, much like the concept of 'survival rate' in cancer" p.78 (Ng et al., 2008).

Insight in the patient was linked with recovery orientation. One participant stated:

'Sometimes, for your folks who understand, "I am not well right now, something is the matter"... recovery makes sense. They have a grasp on their illness and they know they are not feeling well, versus I could be feeling better. For other folks who don't have insight into why you are in their life at all, recovery doesn't work' p.41 (Sullivan and Floyd, 2013).

Sub-category 2: Personal Recovery

The Personal Recovery category identified a holistic approach (spanning physical health care, psychological therapies and stress management) where individuality (including client-centred goals, service user autonomy and decision-making) takes precedence and staff and service users work in partnership (through for example coaching, supporting hope) as paramount. Personal recovery was measured by citizenship involvement (including meaningful occupation and social inclusion).

A power shift is involved in client-centred personal recovery support:

'Recovery was viewed as individually determined and predicated primarily on what consumers wanted, not on what professionals perceived as the upper limits of what is possible' p.41 (Sullivan and Floyd, 2013).

'The most prominent idea that emerged when respondents were asked what the concept of recovery means to them is that of holism. This included social factors such as relationships, psychological issues like self-esteem, and practical matters such as living skills, money, education and work' p.208 (Cleary et al., 2013).

Autonomy and decision making are important components of personal recovery support. One participant stated:

"It becomes their choice whether they do these things or not or they can also decide that whatever was initially important isn't important anymore. That's up to them. But if they...if it's still important, then they got to do certain things."

"In the end, it doesn't matter what my thoughts are about discharge planning."

It's about what the client wants and is willing to do." p.55 (Dunlap, 2009).

Supporting hope was a prominent theme. Another participant stated:

'You have to be able to bring your clients along with you ... and have them as invested as much in their recovery as you are. So that is the skill. The most important thing is knowing how to do that, and then holding that vision for them when they can't...sometimes they can't envision their recovery' p.189 (Sullivan and Floyd, 2012).

Sub-category 3: Service-defined Recovery

The Service-defined Recovery category linked to ownership of recovery-orientated care as a concept owned by the organisation where administrative and financially driven goals shape practice. Service-defined recovery was viewed as a tool to reduce costs and measured by service throughput (including discharge) and service accessibility.

Financial and administrative priorities dictate practice:

'Current mental health reimbursement systems do not support recovery. Participants pointed out that federal, state, and local public mental health systems have not framed financial reimbursement systems to reflect recovery-oriented care. Despite the emphasis on recovery in public statements and formal planning documents, public mental health providers are still primarily focused on symptom remission and client stabilization, with limited opportunities to expand the number of reimbursable programs that emphasize community integration and recovery' p.1120 (Rogers et al., 2007).

Recovery orientation can be viewed by staff as something owned by the organisation and therefore supported in order to meet organisational targets:

'Recovery was identified by several participants as a Trust 'initiative'. Despite recognition that the Trust was committed to recovery, there was a lack of clarity about what the Trust meant by recovery, how it related to other initiatives and Trust strategies, and in particular what this meant in terms of the role of services. This led some interviewees to suggest that a recovery approach was being implemented for political reasons, to meet government targets, as a tool for reducing costs, and like previous initiatives, may soon be de-prioritised' (p.7) (Gilburt et al., 2013).

Service users can therefore receive the message that recovery support will mean reduced service input:

'Providers expressed frustration with their role to aid women in recovery. Although participants spoke positively about recovery, the implementation of this guiding vision was fraught with difficulties' (p.314) (Rice, 2009).

One participant stated: *'I have to say that I am really for the idea of recovery, (laughs); I just want to go on record that I am for recovery! But whatever that means for that person, you know. I know so many women that are confused about the whole idea, I try to talk to them about recovery and they ask me 'does that mean you don't want to see me?'' (p.314) (Rice, 2009).*

The three conceptualisations of recovery-orientated practice are not mutually exclusive, and some staff understand their role in supporting recovery as integrative:

'Here, 'medical' intervention is equated with involuntary treatment and medication, and deemed to be just as important as 'recovery'. Thus, Paul attributed successful recovery to a worker's ability to apply equal value to both dimensions of practice by balancing these competing needs against each other' (p.6) (Courtney and Moulding, 2013).

6.3.4 Exploring the relationships between studies

All 22 studies (regardless of their quality rating and methodological design (reported in Table 6.7 and detailed in Appendix 18)) were included in the vote counting process. The vote counting process was used to compare similarities and differences between the findings of each study. For the Personal Recovery category, papers were characterised using categories from the conceptual framework of recovery-orientated practice described in chapter 3, as shown in Table 6.4.

PERSONAL RECOVERY CATEGORY																	
STUDY ID	PROMOTING CITIZENSHIP				ORGANISATIONAL COMMITMENT					SUPPORTING PERSONALLY DEFINED RECOVERY					WORKING RELATIONSHIP		Total
	Seeing beyond service user	Service user rights	Social inclusion	Meaningful occupation	Recovery vision	Workplace support structures	Quality improvement	Care pathway	Workforce planning	Individuality	Informed choice	Peer support	Strengths focus	Holistic approach	Partnerships	Inspiring hope	
ASTON 2012																	0
GILBERT 2013			X	X										X	X	X	5
TICKLE 2012				X			X				X						3
TURTON 2010		X	X				X	X		X			X	X		X	8
FELTON 2006											X			X	X		3
SULLIVA N2013											X				X	X	3
SULLIVA N2012											X					X	2
RICE 2009																	0
WATSON 2011			X									X					2
ROGERS 2007			X														1
DUNLAP 2009		X								X	X		X		X	X	6
COURTN EY2013		X								X					X		3

PERSONAL RECOVERY CATEGORY																	
STUDY ID	PROMOTING CITIZENSHIP				ORGANISATIONAL COMMITMENT					SUPPORTING PERSONALLY DEFINED RECOVERY					WORKING RELATIONSHIP		Total
	Seeing beyond service user	Service user rights	Social inclusion	Meaningful occupation	Recovery vision	Workplace support structures	Quality improvement	Care pathway	Workforce planning	Individuality	Informed choice	Peer support	Strengths focus	Holistic approach	Partnerships	Inspiring hope	
VANLITH 2009				X										X		X	3
CLEARY 2013														X			1
HUNGER FORD 2013																	0
BATTER SBY2012			X	X						X	X					X	5
SCHWAR TZ2013														X			1
KIDD 2014	X										X				X		3
PIAT2012														X	X		2
NG2008																	0
KAEWPR OM2011			X					X									2
CONE 2012			X	X									X	X			4
Total	1	3	7	5	0	0	2	2	0	4	7	1	3	8	7	7	57

Table 6.4 Vote counting for Personal Recovery sub-category

Individual studies contained a median of 2.5 (range 0 to 8, mode 3) of the 16 categories of Personal Recovery. The category with the most studies was Holistic approach (8 studies) followed by followed by Social Inclusion, Informed Choice, Partnerships and Inspiring Hope (7 studies each).

For the Clinical Recovery and Service-defined Recovery categories, for which no existing frameworks exist, papers were characterised using the inductively-derived lower order categories. Table 6.5 shows the vote counting for the Clinical Recovery category.

STUDY ID	CLINICAL RECOVERY									
	Deficit perspective	Medication adherence	Symptom remission	Gaining insight	Absence of relapse	Risk/crisis management	Meet basic survival needs	ADL task mastery	Stabilising or fixing patients	Total
ASTON2012	X								X	2
GILBURT2013	X	X	X			X			X	5
TICKLE2012						X				1
TURTON2010		X								1
FELTON2006		X		X		X		X	X	5
SULLIVAN2013		X		X					X	3
SULLIVAN2012										0
RICE2009										0
WATSON2011	X		X							2
ROGERS2007			X			X			X	3
DUNLAP2009	X					X				2
COURTNEY2013	X	X								2
VANLITH2009										0
CLEARY2013		X	X			X				3
HUNGERFORD 2013										0
BATTERSBY2012	X									1
SCHWARTZ2013						X			X	2
KIDD2014						X				1
PIAT2012						X	X			2
NG2008		X	X		X			X	X	5
KAEPROM2011		X	X		X			X	X	5
CONE2012										0
Total	6	8	6	2	2	9	1	3	8	45

Table 6.5 Vote counting for Clinical Recovery sub-category

Individual studies contained a median of 2 (range 0 to 5, mode 2) of the nine sub-categories of Clinical Recovery. The sub-categories with the most studies were

Risk/Crisis Management (9 studies), Medication Adherence and Stabilising Or Fixing Patients (8 studies each). Table 6.6 shows the vote counting for the Service-defined Recovery category.

STUDY ID	SERVICE-DEFINED RECOVERY							
	Owned by the organisation	Administrative/ financially driven goals	A tool to reduce costs	Service throughput/moving-on	Discharge	Reducing service accessibility	Setting limits on service provision	Total
ASTON2012								0
GILBURT2013	X			X				2
TICKLE2012					X			1
TURTON2010								0
FELTON2006		X			X	X		3
SULLIVAN2013								0
SULLIVAN2012								0
RICE2009					X			1
WATSON2011		X			X		X	3
ROGERS2007		X						1
DUNLAP2009		X			X		X	3
COURTNEY2013			X				X	2
VANLITH2009								0
CLEARY2013				X				1
HUNGERFORD 2013								0
BATTERSBY2012								0
SCHWARTZ2013								0
KIDD2014								0
PIAT2012	X	X						2
NG2008								0
KAEWPROM2011								0
CONE2012		X						1
Total	2	6	1	2	5	1	3	20

Table 6.6 Vote counting for Service-defined Recovery category

Individual studies contained a median of 0.5 (range 0 to 3, mode value 0) of the seven sub-categories of Service-defined Recovery. The sub-categories with the most studies were Administrative/Financially Driven Goals (6 studies) and Discharge (5 studies).

The primary focus of Personal Recovery was a holistic approach and an emphasis on social inclusion, choice and hope-inspiring partnership working. The primary focus of Clinical Recovery was risk, medication and clinical management. The primary focus of Service-defined Recovery was a focus on organisational goals and on discharge. Overall, staff understandings spanned personal, clinical and service-defined recovery, with strongest mapping for personal recovery (19 out of 22 studies) and weakest mapping for service-defined recovery (12 out of 22 studies). Included studies were spread across all three conceptualisations of recovery-orientated practice with no difference in country, setting or professional groups. The characteristics (country, study setting, participant professional group(s)) of each study (n=22) are detailed in Table 6.7 alongside vote counting of the three different conceptualisations of recovery-orientated practice.

#	Study ID	Quality Score (out of 18)	Country	Setting	Staff Group	Clinical recovery	Personal recovery	Service-defined recovery
1	ASTON2012 (Aston and Coffey, 2012)	6	UK	In-patient	Nurses	X		
2	GILBURT2013 (Gilburt et al., 2013)	9	UK	Across settings	Team leaders	X	X	X
3	TICKLE2012 (Tickle et al., 2014)	11	UK	Across settings	Clinical psychologists	X	X	X
4	TURTON2010 (Turton et al., 2010)	12	Europe	In-patient	MDT	X	X	
5	FELTON2006 (Felton et al., 2006)	13	USA	Community	MDT	X	X	X
6	SULLIVAN2013 (Sullivan and Floyd, 2013)	12	USA	Community	Case managers	X	X	
7	SULLIVAN2012 (Sullivan and Floyd, 2012)	11	USA	Community	Case managers		X	
8	RICE2009 (Rice, 2009)	4	USA	Community	Case managers			X
9	WATSON2011 (Watson et al., 2011)	8	USA	Across settings	MDT	X	X	X
10	ROGERS2007 (Rogers et al., 2007)	2	USA	Across settings	Psychiatrists	X	X	X
11	DUNLAP2009 (Dunlap, 2009)	14	USA	Not known	Social workers	X	X	X
12	COURTNEY2013 (Courtney and Moulding, 2013)	11	Australia	Community	Social workers	X	X	X
13	VANLITH2009 (Vanlith et al., 2009)	11	Australia	Community	Art therapists		X	
14	CLEARY2013 (Cleary et al., 2013)	7	Australia	In-patient	Nurses	X	X	X
15	HUNGERFORD20 13	10	Australia	Not known	MDT		X	

#	Study ID	Quality Score (out of 18)	Country	Setting	Staff Group	Clinical recovery	Personal recovery	Service-defined recovery
	(Hungerford and Kench, 2013)							
16	BATTERSBY2012 (Battersby and Morrow, 2012)	14	Canada	Community	MDT	X	X	
17	SCHWARTZ2013 (Schwartz et al., 2013)	7	Canada	Community	MDT	X	X	
18	KIDD2014 (Kidd et al., 2014)	8	Canada	In-patient	MDT	X	X	
19	PIAT2012 (Piat and Lal, 2012)	14	Canada	Across settings	MDT	X	X	X
20	NG2008 (Ng et al., 2008)	9	Hong Kong	Across settings	Psychiatrists	X		X
21	KAEPROM2011 (Kaewprom et al., 2011)	7	Thailand	In-patient	Nurses	X	X	
22	CONE2012 (Cone and Wilson, 2012)	6	New Zealand	Across settings	Occupational therapists		X	X
Total						17	19	12

Table 6.7 Summary of included studies (n=22)

Year of publication was not a factor in determining staff understanding indicating that conceptualisations have been evident for while. For example, the oldest study (published in 2006) mapped all three conceptualisations of recovery as applied to practice.

High quality and low quality studies did not differ in their profiles and also referred to all three conceptualisations of recovery. Three of the four studies assessed as high quality (scored 13 or 14 out of a possible 18) identified all three conceptualisations in the findings . The study identified as the lowest quality (scored 2 out of a possible 18) also highlighted the three conceptualisations of recovery as applied to practice.

6.3.5 Assessing the robustness of the synthesis

To ensure a robust synthesis and methodological rigour, data checking was undertaken at each stage of the data collection and analysis.

1. Searching and inclusion phase: To ensure the internal consistency of the review, a random 20% (n=2,033) of sifted papers were double rated, with agreement on 1,972 (97%). The 61 papers with discordant ratings were obtained in full, and 2 (3%) were assessed as eligible for inclusion. All 245 papers retrieved in full were double rated for inclusion. The resulting level of concordance achieved between raters was 95%.

2. Validation of stage 1: The theory was developed using grounded theory, a systematic rigorous methodology, and was based on the perspectives of 97 staff participants in England.

3. Validation of stage 2 and 3: Data relevant to the research question from included studies (n=22) were independently extracted and tabulated by two analysts to reduce sampling bias. Definitions for each category identified in the developed theory (element 1) were used to ensure consistency between analysts. The same two analysts completed separate thematic analysis of the preliminary framework using UK/European studies. The impact of the author's previous knowledge and clinical background on the development of the coding framework was considered throughout and reflective notes were kept to record coding decisions. The results of the narrative synthesis were presented to staff delegates at an international conference (Refocus on Recovery 2014) for expert critical appraisal and to test out and refine the findings.

6.4 Discussion

The aim of the review was to increase clarity about how staff understand recovery-orientated practice. This review found a lack of theoretical clarity about what supporting recovery in practice means, and identified the first empirical conceptualisation of a new understanding of recovery.

Using the grounded theory developed in Chapter 5 as a framework for analysis, the overarching category to emerge from the narrative synthesis was Staff Role Perception. Previously identified as a sub-category of Competing Priorities, Staff Role Perception came to prominence in this review. It refers to the ways staff understand and prioritise their work roles, and how they perceive their role in supporting recovery. As discussed in Section 5.3, the identity of staff, that is, who staff think they are in their context (staff role perception), is central to the sensemaking process and to shaping how staff interpret cues and act (Weick, 1995). The findings presented here suggest that the way staff understand and perceive their work role influences their conceptualisation of recovery as applied to practice.

Service-defined Recovery: A new concept

A total of 22 studies describing staff conceptualisations of recovery-orientated practice were included. Narrative synthesis identified three sub-categories of staff role perception, that is three conceptualisations of recovery-orientated practice: Clinical Recovery, Personal Recovery and Service-defined Recovery. Clinical Recovery refers to a focus on the professional as an expert working within an established health infrastructure, with clinical tasks shaping recovery-orientated practice. Personal Recovery involves supporting personally defined recovery through person-centred goals, service user autonomy and a strengths focus. Service-defined Recovery is owned by the organisation, with a focus on administrative and financial goals achieved through service throughput and setting limits on service provision. The concepts of clinical recovery (Lieberman et al., 2008) and personal recovery (Slade, 2009b) are well documented, and were described in Chapter 2. Service-defined recovery extends the meaning of recovery-orientated practice by translating recovery into practice according to the goals and financial needs of the organisation: an understanding of recovery which is owned by the mental health system, and which focuses on reducing costs by limiting access to

services and setting goals for discharging and moving people more quickly through the system.

The conceptualisation of service-defined recovery may have arisen for at least two reasons. First, national policy dictates that mental health services are to be recovery-orientated. In the absence of concrete clinical guidelines for recovery-orientated care, the findings presented here suggest that process indicators (such as throughput and discharge) have been used by organisations to fill the gap and to operationalise recovery for practice. Second, the need for organisational survival (to reduce service costs) may have led to recovery support being used as a means to focus on organisational goals and to meet organisational demands (Braslow, 2013).

Like the focus on business priorities (reported in Chapter 5), this attempt to operationalise recovery support through the lens of organisational priorities has been criticised, both by people working in the system (Slade et al., 2014) and by people who use mental health services (Mental Health 'Recovery' study working group, 2009, Mind, 2008). It has been suggested that the various understandings of recovery reflect the discrepant aims and agendas of different stakeholders (Bonney and Stickley, 2008, Pilgrim and McCranie, 2013). Indeed, Hopper (2007) suggests that the ambiguity surrounding recovery has its strategic uses (Hopper, 2007). For example, service-defined recovery uses recovery to meet service demands (focusing on reduced financial expenditure rather than quality) which do not align with the priorities of service users (Newman Taylor et al., 2015). It can also be argued that service-defined recovery and clinical recovery predominantly align with system-level understanding and personal recovery shifts the conceptualisation towards an individual-level understanding (Slade and Longden, 2015). This thesis proposes that all three conceptualisations of recovery-orientated practice are considered when assessing recovery-orientation and supporting implementation of recovery-orientated practice in mental health services to ensure recovery-orientated mental health services are effectively tailored to support a diversity of stakeholder values.

6.4.1 Implications for Policy and Practice

Service-defined recovery will influence the delivery, management and evaluation of recovery-orientated practice. This clarification of staff understanding of recovery-orientated practice indicates that organisational transformation towards a recovery orientation needs to be as focussed on how the mental health system is managed

as on the interventions being provided (Novotna et al., 2011). This is echoed in the findings of the conceptual framework of recovery-orientated practice (reported in Chapter 3) where Organisational Commitment was one of four practice domains, and where it is recommended that organisational culture gives primacy to recovery by focusing on and adapting to the needs of people rather than those of services.

Professionalism and Ethics

Identity and staff role perception is not only central to making sense of recovery in practice but also contributes to an individual's sense of professionalism, that is professional standards and conduct (Bhugra and Malik, 2011). Professionalism frameworks have been developed for all key professions that describe required standards of technical ability as well as providing acceptable code of conducts (Agenda for Change Project Team, 2004, The British Psychological Society, 2009, Royal College of Psychiatrists, 2014, College of Occupational Therapists, 2015). However, the Health and Care Professions Council (2014) write: *'Much of the recent literature around medical professionalism has focused on professionalism as a competency, or something which can be taught, developed, measured and assessed. However, there is another level to professionalism, related more to professional identity than to behaviour: individuals' perception of themselves as professionals'* (p.5) (Health and Care Professions Council, 2014).

Practitioners are responsible for meeting the diverse needs of service users, managers, commissioners and policy makers (Bhugra and Malik, 2011), and are therefore required to manage potentially competing work priorities. Professional frameworks need to acknowledge support that may be necessary to assist staff to develop new, and to harness existing skills when exercising judgment to mediate between competing or conflicting demands. Alongside, and with the acknowledgement of three types of recovery support, clinical recovery, personal recovery and a new influence of service-defined recovery, there are also expectations to manage competing demands in relation to recovery. For example, services need to balance the needs of professional expectations, individual priorities and organisational culture. Job insecurity may also arise if staff do not accord fully with organisational key performance indicators. Therefore, mental health services need confident and empowered staff who have the skills and organisational support to exercise judgment in arbitrating between the demands of the organisation and of individual service users. Mental health services need to create an empowering culture where staff are supported to make defensible decisions and to manage

competing priorities. This is also echoed in the findings of the conceptual framework of recovery-orientated practice (reported in Chapter 3) where the category called Workforce Planning (within the Organisational Commitment practice domain) identified staff support as paramount to successful recovery orientation in services. The importance of staff morale has been acknowledged as well as ensuring that the participation staff extend to people who use mental health services is also extended to them (Needham and Carr, 2009).

Personal recovery values autonomy and promotes partnership working. This emphasis can raise ethical tensions if professionals exert authority or expertise over mutual collaboration and do not promote service user involvement or responsibility of individuals who live with mental illness for their own care (Marshall et al., 2007). Equally, where recovery support focuses on wellness, ethical tensions can emerge if symptom management is the usual emphasis of treatment (Schwartz et al., 2013). Park and colleagues (2015) acknowledge the centrality of ethical reasoning to successful implementation of recovery-orientated practice and propose a study on the ethics of transforming care. They write: *'The inherent conflict between the values, basic concepts, knowledge base, working practices and goals of recovery, and traditional approaches will require more than acquiring a new language or set of skills'* (p.2) (Park et al., 2015).

Co-production as an alternative approach to service development

International initiatives to address service transformation and to promote recovery-orientation in mental health organisations are gaining recognition, such as Partners in Recovery in Australia (Australian Government Department of Health and Ageing, 2012) and Recovery to Practice in USA (Del Vecchio, 2015). Based on the principles of co-production, the Implementing Recovery through Organisational Change (ImROC) programme in UK provides consultation and training to address key organisational challenges and to develop recovery-orientated services with a focus on personal recovery (Boardman and Shepherd, 2009, Repper and Perkins, 2013). Co-production is *'a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities'* (p.3) (Slay and Stephens, 2013). Six principles provide the foundation of co-production: i) an assets-based approach is used where people become equal partners in designing and delivering services; ii) opportunities are provided to recognise and build on existing capabilities; iii) reciprocal relationships are

developed that have mutual responsibilities and expectations; iv) peer networks are accessed to promote to transfer knowledge; v) distinctions between professionals and service users are removed by reconfiguring how services are developed and delivered; vi) services work in partnership to provide a facilitative role (Slay and Stephens, 2013).

The conceptual framework of recovery-orientated practice reported in Chapter 3 identified Quality improvement as a sub-theme of the Organisational Commitment practice domain. Within the sub-theme, it was recommended that services are directed by and responsive to service users, families and carers. Co-production is emerging as a powerful model to support the active participation of individuals who use services and values equal partnership working between staff and service users in delivering outcomes that are negotiated and agreed collaboratively. Co-production is a model of service delivery which recognises people as assets, values 'work' differently, promotes reciprocity and builds social networks (Boyle and Harris, 2009). Beck and colleagues (2015) suggest that co-production can lead to a wiser and more compassionate organisation (Beck et al., 2015). Co-production can be used to complement existing organisational processes and may hold an antidote to management processes being the key elements of service-defined recovery. For example, using lived experience to inform each level of leadership in the mental health system might be one way to influence the meaning of service-defined recovery and to address the view that recovery has been co-opted for the benefit of services.

Co-production affirms the expertise of individuals accessing services and uses the resources of people who live with mental illness to contribute to meeting their own needs and/or those of others. The expertise of staff is also valued, alongside the positive outcomes that come from equal partnership working between staff and service users. Despite this, implementing co-production is challenging and requires negotiated relationships between planners, commissioners, organisation managers and front-line staff, people who use services, and those who care for people who use services. Co-production must be associated with an increase of resources rather than a threat to staff status and as Needham and Carr write: *'it is necessary to be sensitive to and open about differences between the values, incentives and perception of roles between different stakeholders'* (p.8) (Needham and Carr, 2009).

Service user experience as a key indicator of service quality

As reported in Chapter 5, financing and commissioning demands influence clinical decisions that affect value and quality of care (Slade et al., 2014). Organisations seek to improve value for money, typically through paying services by results which are measured as activity targets or service throughput (for example, reduced hospital admissions, discharge) (Department of Health, 2012c, Department of Health and Human Services, 2003), rather than as personalised service user outcomes or experience of care. Future quality indicators which connect payment to recovery and to service users' experiences could replace the existing focus on organisational processes (Newman Taylor et al., 2015). Services can capture service user experience by using patient-rated experience measures (PREMs) alongside patient-rated outcome measures (PROMs) as well as clinician-rated outcome measures (Department of Health, 2013b, Shepherd et al., 2014).

One example of a PREM is a service user-rated measure of staff support for personal recovery, called INSPIRE, which was developed and evaluated as part of the REFOCUS programme of research (summarised in Section 1.2) (Williams et al., 2015). Using the conceptual framework of recovery-orientated practice (reported in Chapter 3) as its theory base, INSPIRE measures service user experience of recovery support received from their named mental health worker. The measure involves two sub-scales derived from the conceptual framework of recovery-orientated practice: Supporting personally defined recovery (called Support) and Working relationship (called Relationship). Supporting personally defined recovery details working practices that support recovery. Working relationship highlights that an equal partnership is key for this support to be useful. Items (n=20) included in each sub-scale were generated from the CHIME framework (conceptual framework for recovery, reported in Section 2.1) and include the identified five recovery processes (Connectedness, Hope, Identity, Meaning and Purpose, and Empowerment). INSPIRE can be used as a means of collecting performance data to support mental health service management.

6.4.2 Strengths and limitations

This is the first systematic review and narrative synthesis of staff conceptualisations of recovery-orientated practice. Staff perspectives have been relatively absent from the recovery literature. In the present review, only 22 of the 245 papers accessed in full and assessed for eligibility focused on staff understanding. Adopting a transparent systematic review and narrative synthesis methodology addresses

some of the criticisms regarding rigour (for example transferability of findings, reported in Section 7.2) and increases confidence in the findings (Mays and Pope, 1995). One critique is that systematic reviews are typically atheoretical (Gough et al., 2012). Narrative synthesis addresses this by using theory to develop the analysis, and in the case of this thesis, adds value by contextualising a previously developed grounded theory (reported in Chapter 5). The robustness of the review was enhanced by three approaches to validating the framework, namely the double-rating of a proportion of papers to assess eligibility, double-coding and data extraction of included papers, and presentation to staff attending an international conference. The use of narrative synthesis builds on the developed grounded theory (used in element 1) and enhances its transferability by expanding beyond the setting used to develop the initial theory (reported in Chapter 5). For example, research on staff perspectives of working in in-patient settings were included in the systematic review sample alongside staff perspectives from community-based settings.

A limitation of the review was that the thematic analysis was a secondary analysis of the interpretations presented by the authors of the original papers, rather than being based on primary data. Furthermore, the findings represent one interpretation of the data and should not be viewed as a definitive or rigid synthesis of staff understanding of recovery-orientated practice. One tool to enhance rigour is checking the synthesis with authors of primary studies to test the accuracy of the interpretations developed during the synthesis and the extent to which they are supported by the primary data (Popay et al., 2006). Checking with primary authors was regarded as impracticable, but is a method for future consideration in terms of further validating the research. Papers included in the review were restricted to only those written in English, and the search strategy could have been extended, for example to include relevant conference proceedings. With only 22 of the 245 papers accessed in full and assessed for eligibility focusing on staff understanding, it might be argued that the data pool is limited from which to draw conclusions. Despite these limitations, the review has produced a useable and valuable contribution to knowledge for use in both future clinical and research applications.

6.4.3 Conclusion and implications for the thesis

Three staff conceptualisations of recovery-orientated practice emerged. Whilst the notions of supporting personal recovery and clinical recovery are well documented, a new concept of service-defined recovery was identified. Chapter 7 discusses the study findings as a whole and draws together the conceptual framework of recovery-

orientated practice, the grounded theory and the results from the systematic review and narrative synthesis.

Chapter 7. Synthesis and discussion of findings

Chapter 7 integrates the study findings and draws together the conceptual framework of recovery-orientated practice, grounded theory of staff perspectives on supporting recovery and systematic review/narrative synthesis of staff understanding of recovery-orientated practice. The overall strengths and limitations of the study are reported, and scientific and clinical implications are presented.

Chapter 7 comprises six sections. Section 7.1 draws together the conceptual framework of recovery-orientated practice, grounded theory and systematic review. Section 7.2 describes the strengths and limitations of the PhD study. Section 7.3 discusses scientific and clinical implications. Section 7.4 discusses areas for future research. Thesis contribution to knowledge is reported in Section 7.5, as well as how the findings contributed to, and informed the wider REFOCUS programme (introduced in Chapter 1). Finally, Section 7.6 presents the conclusion.

7.1 Summary and synthesis of findings

The research aims are restated here to guide the reader through the process from aims to synthesis of findings. The broad research aim was to explore staff perspectives on supporting recovery. Two specific aims emerged as the study progressed:

Aim 1: To identify staff perspectives on factors that help or hinder their efforts to provide support for recovery

Aim 2: To investigate staff understanding of recovery-orientated practice.

Figure 7.1 shows the study outputs and illustrates the iterative synthesis process used to develop an integrated summary of staff perspectives on recovery-orientated practice.

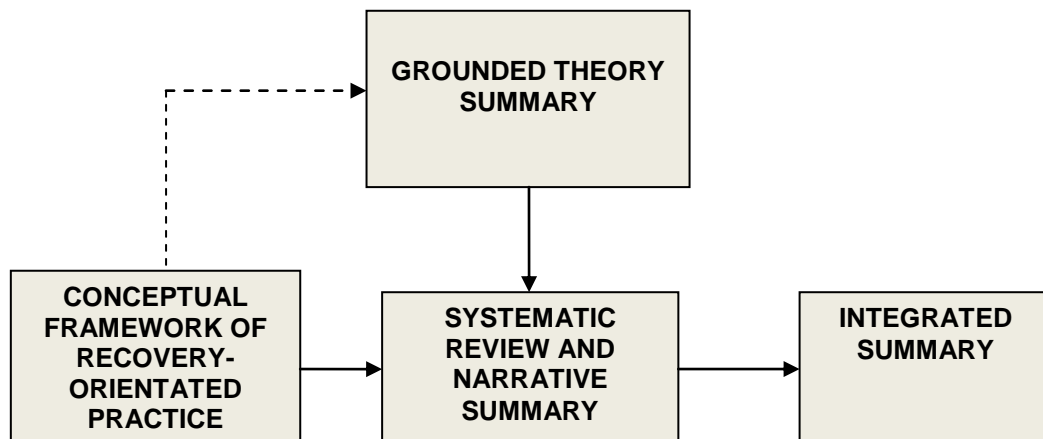


Figure 7.1 Synthesis process

The grounded theory of staff perspectives provided a foundation to the narrative synthesis process where the findings were used as a framework of analysis in the systematic review and narrative synthesis of staff understanding of recovery-orientated practice. The coverage of personal recovery in staff participant accounts was evaluated by mapping the conceptual framework of recovery-orientated practice to the final grounded theory coding framework.

The grounded theory findings are summarised here and provided a foundation to the narrative synthesis process. The grounded theory study of staff perspectives (n=97) on supporting recovery (reported in Chapter 5) identified a core category, called Competing Priorities. Participants described conflicting demands and priorities for practice that hindered their success in supporting recovery. The same demands and priorities also contributed to a conceptual uncertainty and influenced how staff made sense of recovery-orientated practice (Weick, 1995). Three sub-categories describing the competing priorities for practice were identified: Health Process Priorities, Business Priorities and Staff Role Perception, and are illustrated in Figure 7.2.

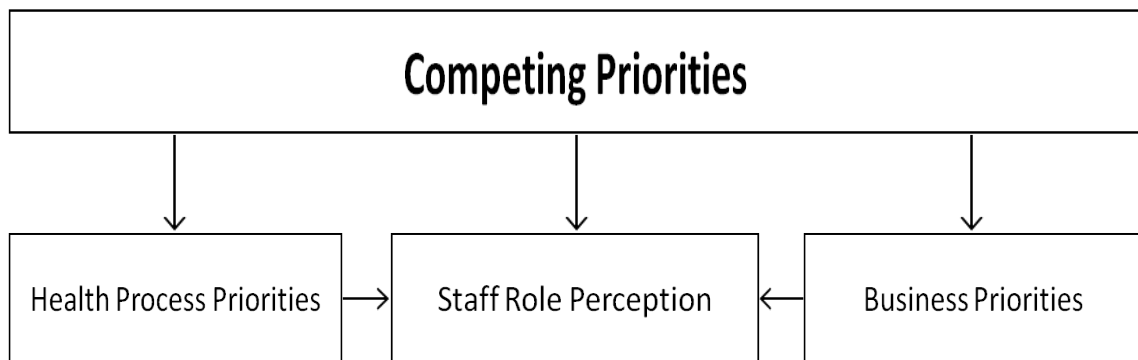


Figure 7.2 Grounded theory summary

Health Process Priorities focus on illness and risk. Business Priorities focus on organisational requirements such as commissioning targets. Staff Role Perception encompasses priorities of individual workers including the expectations they have of service users in shaping their own care (Forchuk et al., 2003). Staff Role Perception is also influenced by the health process and business competing priorities. In other words, staff work roles are influenced by individual staff priorities for practice, health process priorities and business priorities.

The grounded theory was used as a framework of analysis in the systematic review and narrative synthesis of staff understanding of recovery-orientated practice. To summarise, the grounded theory sub-category called Staff Role Perception took prominence in the narrative synthesis of review papers (n=22), reported in Chapter 6. As indicated in both the grounded theory and narrative synthesis, the values and priorities of individual workers were found to shape their practice. For example, the ways that staff understand and prioritise their work roles, and how they perceive their role in supporting recovery influenced staff understanding of recovery-orientated practice. In the narrative synthesis, three sub-categories of Staff Role Perception were identified, indicating three conceptualisations of recovery-orientated practice: Clinical Recovery, Personal Recovery and Service-defined Recovery as illustrated in Figure 7.3.

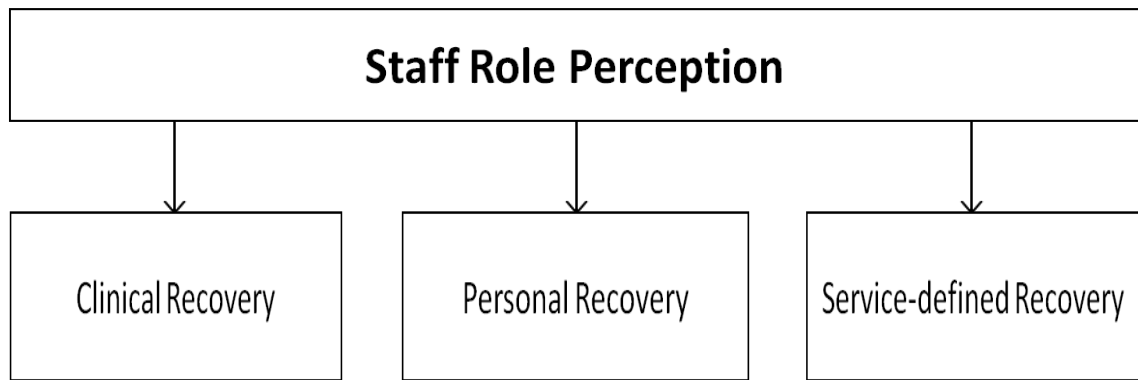


Figure 7.3 Narrative synthesis summary

The concepts of clinical recovery and personal recovery are well documented (Davidson et al., 2005, Lieberman et al., 2008), and were reviewed in Chapter 2. Service-defined recovery is a new conceptualisation, an operationalisation of recovery by the mental health system based on the needs of the organisation. While personal recovery and clinical recovery have been identified as distinct concepts (Tse et al., 2014), with different recovery outcomes (Macpherson et al., 2016), the narrative synthesis (reported in Chapter 6) suggests overlap of staff understanding spanning personal recovery, clinical recovery and service-defined recovery. While staff understanding of recovery-orientated practice spanned all three conceptualisations of recovery-orientated practice, vote counting conducted as part of the narrative synthesis process identified personal recovery as the most reported conceptualisation of recovery (19 out of 22 studies), with least prominence given to service-defined recovery (12 out of 22 studies).

While the included systematic review papers (reported in Chapter 6) gave most prominence to an understanding of personal recovery, staff participating in the grounded theory study (reported in Chapter 5) felt that their practice was not reflective of the practice domains identified in the conceptual framework of recovery-orientated practice (reported in Chapter 3). The coverage of personal recovery in staff participant accounts was subsequently evaluated (post-grounded theory coding) by mapping the conceptual framework of recovery-orientated practice to the final grounded theory coding framework, shown in Appendix 20. Staff participants (n=97) made reference to 10 of the 16 conceptual framework categories; most notably, service user rights (promoting citizenship domain) and peer support (supporting personally defined recovery) were missing. Four of the five sub-categories of Organisational Commitment were also not reported, with reference

only to care pathway. An understanding of personal recovery is indicated in these findings even though staff participants recruited to the early focus groups felt the conceptual framework of recovery-orientated practice was not reflective of their practice experiences.

The coverage of clinical recovery in staff participant accounts was identified by mapping the grounded theory coding framework to the clinical recovery categories generated from the narrative synthesis thematic analysis. Five of nine categories were included, with a focus on deficit perspective, symptom remission, absence of relapse, and stabilising or fixing patients. Like the papers included in the narrative synthesis, the grounded theory also highlighted a focus on risk management. The coverage of service-defined recovery in staff participant accounts was identified by mapping the grounded theory coding framework to the service-defined categories generated from the narrative synthesis of included review papers of which all seven categories were identified. It could be argued that the prominence of service-defined recovery was influenced by using a deductive framework to generate the narrative synthesis codes.

The systematic review was also updated (using one database) during the synthesis process. The MEDLINE database was searched from 2013 to 14 June 2016 and 697 records were identified. A further three studies were identified through expert consultation (n=1), internet searching (n=1) and searching reference lists (n=1). 696 records were excluded from the title and/or abstract and four full-text articles were retrieved and assessed for eligibility. Three of the four studies were excluded due to the use of a pre-defined framework of recovery-orientated practice (n=2) or insufficient data (i.e. conference abstract (n=1)). One study was eligible for inclusion in the review (Kidd et al., 2015). This Australian 12-month action-research study with consumers (n=6), clinicians (n=4) and a carer explored the meaning of recovery-orientated practice across in-patient and community mental health services. Stakeholder data were analysed separately. Staff participants (nurses and doctors) felt their practice focused on clinical recovery but demonstrated an awareness of the concept of personal recovery. Time pressures and workloads were identified as barriers to supporting recovery alongside staff holding low expectations of service users (Kidd et al., 2015).

The results from the grounded theory study and the narrative synthesis (thematic analysis) were also integrated and the resulting synthesis is illustrated in Figure 7.4.

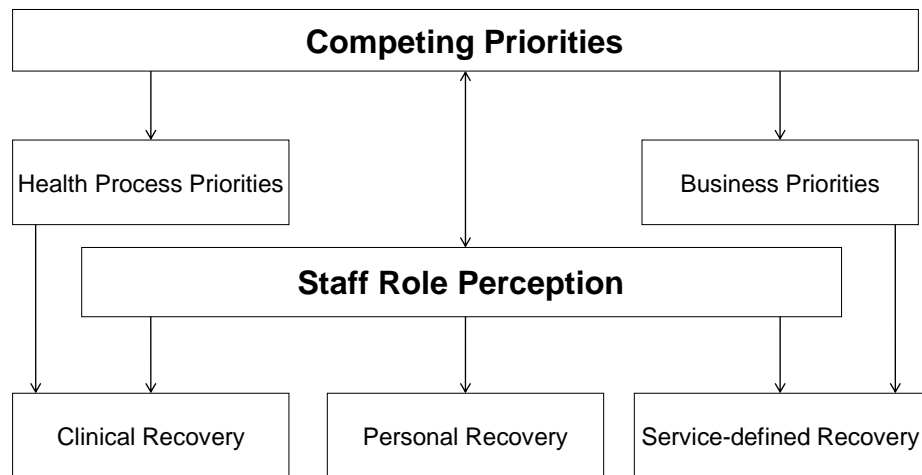


Figure 7.4 Integrated summary

Combining the grounded theory and narrative synthesis (thematic analysis) findings identified Competing Priorities for practice and Staff Role Perception as core influences that affect the success of supporting recovery and that inform staff understanding of recovery-orientated practice. Health Process Priorities connect with Clinical Recovery, where traditional health process priorities are orientated around support for clinical recovery. Health professionals work as experts within an established health infrastructure and clinical tasks shape recovery-orientated practice. For example, clinical guidelines typically place value on objective evidence (Dopson and Fitzgerald, 2005), and the traditional metrics of worker productivity (for example, number of patients seen and completed risk assessments) and outcome (for example, clinician-rated outcome measures) that match clinical recovery assumptions (Department of Health, 2013b). Some staff members felt they must comply within organisation and service parameters, and appeared to be influenced by business priorities (that involve prioritising financial and organisational concerns). Business Priorities relate to the new concept, Service-defined Recovery, which is owned by the organisation and has a focus on service goals. For example, commissioning priorities and process indicators such as throughput and discharge have been used to assess and determine the stage of recovery (from recovery-ready to recovered) of individuals accessing mental health services. There was a strong connection between staff role perception and personal recovery. Staff who

identified themselves as pro-recovery appeared to be influenced by personal values and professional maturity where traditional values and power relations were challenged. Staff attitude was central, alongside job value (for example, esteem of professional role) in determining priorities for practice.

The need for recovery-orientated practice to be promoted across health system levels is evident throughout this thesis: at a societal level (promoting citizenship), an organisational level (organisational commitment) and an individual level (supporting personally defined recovery and working relationship). Table 7.1 illustrates the system level priorities identified within each sub-study of the thesis.

THESES SUB-STUDY (n=3)	SYSTEM LEVELS			
	Society	Organisation	Individual Staff	Service User
CONCEPTUAL FRAMEWORK OF RECOVERY- ORIENTATED PRACTICE	X	X	X	X
GROUNDING THEORY	X	X	X	
NARRATIVE SYNTHESIS	X	X	X	

Table 7.1: Recovery support across system levels

Clinical recovery (and health process priorities) address some societal needs such as ethical imperatives and risk. Service-defined recovery (and business priorities) meet organisational needs such as commissioning demands. Staff role perception and identity determines how clinicians view their work role in terms of supporting recovery (and managing competing priorities) which includes the expectations they have of service users to be equal partners in their own care. Staff conceptualisations of recovery-orientated practice have consistently under-emphasised the role of service users in supporting recovery.

7.2 Overall strengths and limitations

Study context

The findings are specific to the study context. The study was undertaken at a time (2010-2014) of national policy changes to adult mental health services, which included having public sector targets for significant cost savings, and which led to subsequent pressures on organisations to re-evaluate their priorities and to reconfigure their services. The No Health Without Mental Health (2011) long-term mental health strategy for England set out six key targets including improvements in patient centeredness and recovery (Department of Health, 2011). However, this policy was issued around the same time as the Health and Social Care Act (2012) (Department of Health, 2012a) which provided for an extensive reorganisation of NHS services and substantial restructuring of commissioning and provider arrangements. A set of mandates commonly known as the 'Nicholson challenge', which propose the task of improving quality while making efficiency savings of £15–20 billion between 2011 and 2014, were also put forward at this time (House of Commons Health Committee, 2014).

The significant organisational changes which occurred during the research process because of this context may have influenced staff perspectives on supporting recovery. For example, in one organisation, services that were configured according to geographical location were reorganised around psychiatric diagnosis. Another organisation introduced a local non-discriminatory mental health service model called "Fair Horizons" where existing teams were merged together to provide a single access point for all working age adult, older age adult, child and learning disability referrals.

The grounded theory data presented in this thesis were collected from staff working in NHS mental health organisations in times of austerity, under regulatory regimes, and with metrics related to cost. Financial constraints and business priorities may have received less focus if the study was conducted in another context. The findings of the systematic review and narrative synthesis do however indicate that an institutionally-defined level of recovery is evident across settings and countries.

The study was also influenced by the context of the REFOCUS programme of research within which it was conducted (summarised in Chapter 1). Most notably, the thesis research design was shaped to fit the existing programme of research and to ensure the chosen epistemology and methods used were complementary to the REFOCUS protocol (Slade et al., 2011). Ethnographic methods would be very

useful to extend this research through addressing the gaps that have resulted from investigating staff perspectives based on what staff say they do. Observation would compliment staff accounts of practice especially where participants appeared to have difficulty articulating practice examples of recovery-orientated practice (Cresswell, 1998). Observation might also address the limitation of social desirability bias. Alongside, observation might further highlight the ethical dilemmas for staff in reporting examples of recovery-orientated practice (for example, rule breaking by taking time to build partnerships with service users which does not align with organisational priorities on target contact numbers). Another research design for future consideration is participatory action research (Townsend, 2012). The action-research process focuses on practice and compliments the model of coproduction by encouraging dialogues from diverse perspectives among multiple stakeholders, and is a useful framework to address the power differences in mental health services and in supporting recovery (Kidd et al., 2015).

Study design

The conceptual framework was developed from a synthesis of prominent policy and practice guidance documents (n=30). Twenty-one of the 30 documents provided varying levels of information on the guidance development process, and it was not always clear what level of evidence (if any) had been used to develop the guidelines. A criticism of the conceptual framework of recovery-orientated practice is therefore, that it is built on the lack of clarity of what constitutes recovery-orientated practices. Drake and Whitley (2014) state that '*a multitude of interventions, services and approaches [are] proudly (if not glibly) described as recovery-oriented...these could be meaningless shibboleths - new labels for traditional approaches...The rapid proliferation of definitions, models, and research on recovery makes it vitally important to examine the data to disentangle the evidence from the rhetoric*' (p.237) (Drake and Whitley, 2014). While widely-used practice and policy documents were sought for inclusion in the conceptual framework, further consideration should be given to the empirical nature of the included documents.

The decision to use grounded theory was made after data collection had commenced and following consideration of existing theoretical frameworks of implementation (Michie et al., 2005). The first topic guide therefore drew on existing implementation literature and a pre-defined conceptual framework of recovery-orientated practice was also used in early focus groups (reported in Chapter 3). Although efforts were made to encourage individuals' own conceptualisations, the

conceptual framework may have influenced the descriptions of recovery-orientated practice provided by participants. The influence of early background reading, as well as having worked in a role similar to that under study, and sharing a staff perspective, may also have influenced the research process.

The decision to use the grounded theory version (first edition) developed by Strauss and Corbin (Strauss and Corbin, 1990) was made as it acknowledges the potential benefits of using literature and professional experience as sources of theoretical sensitivity (see Section 4.4). It might be suggested that the newer variation of grounded theory based on social constructivism (Charmaz, 2006) could have been used instead but the theoretical focus of symbolic interactionism appeared to suit the emerging data where the focus on the participant's perspective, their experience and social interactions was beginning to explain the processes by which staff support recovery in their day-to-day practice.

The rigour of the study as a whole

Grounded theory methodology was rigorously applied (Strauss and Corbin, 1990) and the sampling frame was geographically and professionally diverse. In total, 97 members of staff were recruited from 51 community teams across five NHS mental health Trust sites, making the sample large for a rigorous qualitative study.

While studies that use grounded theory methodology do not require additional approaches to ensure quality and rigour (Strauss and Corbin, 1990), a strength of the thesis is the use of triangulation, a method used to examine the consistency of findings and to ensure that study findings are rich, robust, comprehensive and well-developed. Most notably, data triangulation was used in the study (sources of data came from staff, team leaders and senior managers), as well as methodological triangulation (use of in-depth interviews, focus groups and included review studies) (Patton, 1999).

Transferability of findings

The grounded theory study focused on NHS mental health service community care provision and did not directly address staff perspectives on supporting recovery in in-patient NHS mental health services. Comparisons with other services could also have been made if recruitment had gone beyond NHS statutory sector staff to include staff working in the private and voluntary sectors.

A transparent systematic review and narrative synthesis methodology was adopted to place the grounded theory in context, and to test the breadth of the theory (Popay et al., 2006). For example, transferability was enhanced by expanding beyond the setting used to develop the initial grounded theory (Whittemore et al., 2001). Research on staff perspectives of working in in-patient settings were included in the systematic review sample alongside staff perspectives from community-based settings. International settings and settings outside the statutory sector were also included in order to generate a grand theory, that is, a theory generated from exploring a phenomenon in a variety of contexts (Strauss and Corbin, 1990). However, as noted in Chapter 6, the findings represent one interpretation of the data and should not be viewed as a definitive or rigid synthesis of staff understanding of recovery-orientated practice. That said, a recent review on the current state of recovery-orientated practice in in-patient settings found the same differences in terms of how staff members understand recovery-orientated practice (Waldemar et al., 2016). Using content analysis, clinical recovery was found to dominate in inpatient settings. While staff demonstrated knowledge of personal recovery, they had difficulty articulating what recovery is and how it applied to their practice. The authors also write: *'contradictory structures in the organization create competing demands, which take priority over the individual needs of the patient...'* (p.601). Competing demands that challenge recovery support were service throughput and discharge (Waldemar et al., 2016).

7.3 Scientific and clinical implications

The term "recovery" can be invested with many meanings and for many reasons (Wittgenstein, 1953). It may then be unsurprising that the concept has been institutionally-defined. Indeed, *"working misunderstandings"* are not specific to recovery (p.848) (Hopper, 2007). For example, the care in the community paradigm was operationalised by the mental health system with changed meaning. Deinstitutionalisation was considered essential, from a humanitarian and moral perspective, to improve the quality of lives of those individuals residing in long-stay institutions (Parr, 2008). However, the general aim of services became to improve the cost-effectiveness of service provision rather than to improve the quality of care (Hadley and Clough, 1996). Further concerns regarding the development of mental health services on an economic basis are not uncommon (Layard et al., 2006) so it might be considered that the institutional conceptualisation of service-defined recovery is deliberate. Hopper (2007) writes: *'Ambiguity about core values, operational principles, and organisational goals has its strategic uses, among them*

the formation of unlikely coalitions in pursuit of structural change' (page 868) (Hopper, 2007). Service-defined recovery may therefore be understood as an attempt at the systemic level to operationalise recovery-orientated practice while maintaining the status quo of traditional power arrangements.

Personal recovery places more emphasis on the unique knowledge base of individuals who live with mental illness, as opposed to relying on professional expertise (Corrigan et al., 2005). As discussed in Chapter 2, where previously the patient perspective may have been peripheral to practice (i.e. clinical recovery), personal recovery moves the individual experience of those living with mental illness and accessing services to become the first and foremost consideration of the system (Foot et al., 2014, Hibbard and Gilburt, 2014). In contrast, service-defined recovery, gives precedence to organisational priorities, and the needs of individuals who live with mental illness are peripheral. This reinforces the critique that recovery, as it has been incorporated into mental health systems, has been changed to fit the dominant organisational priorities and to avoid addressing the central institutional issues of power and control (De Cremer et al., 2012).

Arbitrating between the identified grounded theory competing priorities (health process priorities, business priorities, and staff role perception, reported in Chapter 5) is a question of power and compliance with social norms and organisational expectations (Foucault, 1965). Mental health services have historically been founded on unequal power arrangements, symbolised by detention, coercion and treatment (Pilgrim and McCranie, 2013). While personal recovery is now identified as the intended orientation of mental health services (Department of Health, 2011), British mental health policy remains centred on control and exclusion (Pilgrim and McCranie, 2013), and the power of the system is viewed as conflicting with service user aims (Gilburt et al., 2013). The danger is that a focus on meeting the needs of the organisation (for example, reducing costs) may take priority over the provision of client-centred recovery support and the overall quality of patient care (Francis, 2013).

This thesis makes the case that recovery has been co-opted by the mental health system. One example of co-optation is old practices re-labelled as recovery-orientated but unchanged (Davidson et al., 2006). For example, for some recovery has simply become a new term for rehabilitation (Roberts and Hollins, 2007). As discussed in Chapter 2, many factors contribute to the success of implementing a

paradigm like recovery in mental health services, including conceptual clarity (Damschroder et al., 2009). Personal recovery is vulnerable to being misinterpreted by clinicians and managers due to the complexity and lack of clarity surrounding the paradigm (Slade et al., 2014). For example, making sense of recovery (i.e. the "sensemaking" process discussed in Chapter 5) can be complicated when the concept has been developed outside the system and does not therefore have consistency with systemic assumptions (Weick, 1995). In another example of co-optation, organisations are attempting to support recovery by using existing service-level tools of health management and business planning to respond to the transformation (Shepherd et al., 2014).

7.3.1 Organisational Commitment to Recovery

Alongside conceptual clarity, implementation factors at multiple ecological levels of the health care system (i.e. organisational, and individual context or by factors relating to service users' beliefs or behaviour) will influence the success of supporting recovery (reviewed in Chapter 2) (Von Bertalanffy, 1969). A central theme of the thesis has been the fundamental requirement of an organisational-level commitment to providing recovery support (Crowe et al., 2007).

Organisational commitment is central to supporting system transformation to recovery-orientation (Farkas et al., 2008, Shera and Ramon, 2013) and extensive commitment from practitioners at all levels to embrace a willingness to be innovative about practice is required (Berzins, 2006, Cleary and Dowling, 2009). As noted in Chapter 2, Ramon (2011) states that the organisational level is fundamental in promoting recovery orientation and in adopting a multi-level shift in values, knowledge and skills by challenging existing models of practice. The thesis has identified the need to promote citizenship and a recovery-orientated society outside of mental health services (Henwood and Whitley, 2013). While it can be a challenging view that promoting citizenship is the responsibility of the mental health system (Tew et al., 2012), the recognition of this requirement is gaining momentum (Pelletier et al., 2015, Vandekinderen et al., 2012).

The influence of organisational commitment was also highlighted in a process evaluation nested within the REFOCUS randomised controlled trial (Leamy et al., 2014). Staff were asked to identify barriers and facilitators to implementing the REFOCUS intervention. Competing priorities within the system were identified as a barrier to organisational commitment. One participant explained: '*It [the REFOCUS*

intervention] needs to be priority, given a value within the organisation, because it will otherwise get lost because managing risk, throughput, needing to do assessments will come first. The Trust needs to prove value for money. It needs space and time to allow individuals to be able to go over and beyond what the corporate measured expectations are, or find some sort of meaningful cost based outcome which someone is going to take seriously (p.4) (Leamy et al., 2014). Identified higher order categories in this process evaluation were: Organisational readiness for change and Effective training. The higher order category, *Organisational readiness for change*, included three sub-themes: i) Organisation readiness, consisting of organisational commitment and organisational change, ii) Team readiness, consisting of effective leadership, team stability and composition and recovery practice baseline, and iii) Individual readiness, consisting of attitudes toward the trial and intervention, perceived fit with own existing values, knowledge or practices and willingness to apply to practice (Leamy et al., 2014).

The thesis findings point to the need for organisational alignment around a shared focus on recovery support, including how recovery support is conceptualised in practice. A survey assessed the recovery competencies of 813 community mental health staff working in community mental health services and identified the need for a team approach to support implementation (Stuber et al., 2014). A need has also been identified for commitment to the values and principles of recovery, not as an 'add on', but intrinsic to the culture of the organisation (for example, with recovery values reflected within mission statements, operational policies, and forming part of staff recruitment and training (McKenna et al., 2014b). Brown and colleagues (2010) propose that larger budgets allow for adequate resources to train staff and to offer a broader range of services consistent with a recovery orientation.

Effective leadership (Whitley et al., 2009, Piat and Lal, 2012, Cleary et al., 2016, Chester et al., 2016) and institutional practices (e.g. bureaucratisation of recovery-orientated tools) (Whitley et al., 2009, Piat and Lal, 2012) have also been found to be instrumental in influencing the implementation of recovery support. A recent study exploring social workers' attempts to practise from a recovery-orientated perspective also identified organisational constraints including systemic barriers as influencing their success (Khouri and Rodriguez del Barrio, 2015). In particular, performance outcome measures were identified as influential in determining the type of recovery-orientated practice. They write: *'managers must ensure that the professionals see at least four clients a day and open and close sixty new files a*

year in order to meet the requirements to receive budget renewal... the systemic focus on outcomes may indicate that the service delivery system is paradoxically supporting a meaning of recovery that is fixated on a service user being 'recovered' rather than being in recovery: 'If you can close a file quickly, it is because you are efficient. You're a good worker and you can help people heal quickly.' (pi33-i34) (Khoury and Rodriguez del Barrio, 2015).

Organisational honesty is one strategy that can be utilised to support the three types of recovery. For example, at an organisational level, specifying what is achievable and what is not achievable in terms of supporting recovery because of limitations on service provision e.g. as a result of financial or resource constraints. The message that this organisation can support people in their recovery for up to two years provides a clear expectation and is a more accurate reflection on service provision, than the message that recovery takes two years (as reported in Chapter 5). Clear messages of what recovery-orientated practice means for the workforce (e.g. in terms of job security) are also essential. Providing recovery-orientated care has been shown to reduce staff burnout (Jambrak et al., 2014) and improve job satisfaction (Rabenschlag et al., 2014). A recent study found that psychiatrists are motivated and sustained in their work by focusing on their duty to promote recovery and to develop relationships with service users (Carpenter-Song and Torrey, 2015).

At the individual level, staff attitudes toward recovery have been identified as one factor influencing the success of its implementation (Prytys et al., 2011, Leamy et al., 2014), alongside the perceived fit of recovery-orientation with the worker's own values, knowledge or practices (Schon, 1983, Gunasekara et al., 2013, Leamy et al., 2014) and a commitment and willingness from staff to apply recovery support in practice (Whitley et al., 2009, Piat and Lal, 2012, Leamy et al., 2014). As highlighted in Chapter 6, supporting recovery is also sometimes presented as an ethical challenge (Atterbury, 2014, McKenna et al., 2014a). The inherent ethical tensions (for example, between individual choice and control, and the practice of compulsion and managing risk in mental health services) of balancing clinical recovery and personal recovery have been acknowledged (Pellegrino and Thomasma, 1987), but the ethics of managing service-defined recovery (e.g. managing competing organisational demands) is not yet known. Park and colleagues (2015) raise the question: *'How do practitioners face such ethical tensions and make decisions about the best course of action to take when faced with multiple and often competing*

values embedded in their own practice frameworks and guidelines?' (p.3) (Park et al., 2015).

7.3.2 Co-production as a strategy to influence recovery orientation

As noted in Chapter 5, diverse policy imperatives, theoretical frameworks and aspirations for care can lead to problems in creating environments, structures and processes that support recovery in a way that makes sense to both staff and service users. One strategy to influence recovery orientation across all levels of the health system is co-production (Linhorst et al., 2005). As discussed in Chapter 6, supporting recovery involves promoting service user involvement, and co-production is a model of service delivery which promotes reciprocity by recognising people as assets (Realpe and Wallace, 2010). There is a growing consensus that services need to promote collaborative relationships (Seale, 2016). Co-production can be used to encourage system change by complementing or replacing existing organisational processes, and may hold an antidote to management processes being the key elements of service-defined recovery (Beresford, 2013, Kidd et al., 2015).

Despite this, the implementation of co-production has parallel challenges to implementing recovery-orientation (Gillard et al., 2013, Meddings et al., 2014, Piat et al., 2016, Carr, 2016). Concerns that co-production has too been co-opted by mental health services and 'hijacked' by professionals exist. As reported in Section 6.4, one principle providing the foundation for co-production is providing access to peer support (Faulkner and Jayasree, 2012). Rose (2014) writes: *'peer workers are a subsidiary labour force commanding neither the respect nor the financial remuneration of mainstream staff. They are cheap labour. Some are not paid at all. So once again, we see an alignment between the financial restructuring of society and the recovery discourse'* (p. 218) (Rose, 2014).

Schwartz & Conklin (2015) state that, *'the successful introduction of the recovery paradigm may involve a process of inquiry and negotiation involving service providers and users that allows for mutual exploration of their different mental models and life experiences'* (p.480) (Schwartz and Conklin, 2014). Acknowledging this complexity is necessary to ensure that the different ideologies, values, and models of care are considered. It is also important to recognise that the process of integrating co-production into mental health services may not be straightforward (Eriksen et al., 2013, Gillard et al., 2014, Moran et al., 2014). Treichler and

colleagues (2015) argue that to ensure successful co-production opportunities, involvement must be client-centred, meaningful and accessible to individuals who live with mental illness (Treichler et al., 2015). Building on partnership relationships (Davidson and Chan, 2014, Adnøy Eriksen et al., 2013) will support efforts to provide opportunities for service user involvement in consultation and planning (for example, in the care planning process (Bower et al., 2015, Simpson et al., 2015) as well as involvement in decision-making, training and service provision at the organisational level (Treichler et al., 2015). Simpson and colleagues (2016) identify the need for mutual understandings of recovery across all levels of the mental health system, and suggest that these understandings are developed through the shared participation of staff, service users and carers (Simpson et al., 2016). Kidd and colleagues (2015) argue that *'a partnership approach to service development enables the social determinants of health to be addressed more effectively, as well as supporting individual recovery. These approaches create the potential for genuine transformational change. Approaches that support co-production and co-design have the potential to enable solutions'* (p.38) (Kidd et al., 2015).

7.4 Future research

Two strands of future research have been identified that build on the synthesis of findings:

1. Operationalising recovery for practice

Further research to provide concrete examples of operationalisation of the conceptual framework practice domains into working practices is required to enhance utility for mental health services and practitioners (McKenna et al., 2014a, Chester et al., 2016). While the conceptual framework of recovery-orientated practice provides a conceptual overview of support offered by services and the nature of the relationship between services and service users, and is built from robust analysis, it is not a definitive guide. Although evidence-based approaches and interventions (e.g. Wellness Recovery Action Planning and Individual Placement and Support) are promoted in the guidance, few guidance documents provided examples of operationalisation. Added to this complexity, is a difficulty for staff to articulate how they operationalise recovery support.

Future research to gain closer and more intimate familiarity with the daily practice of staff participants (i.e. ethnography; for example, participant observation, (client contact, team meetings), case note review, and individual interviews) would provide

rich insights into staff social interactions, and extend the thesis findings beyond what staff say they do to support recovery (Pilgrim, 2009). Investigating actual behaviour alongside behavioural intent may also reduce social desirability bias. Research involving the perspective of individuals who receive mental health services would also provide a rich insight into interventions and working relationship characteristics that have supported or have not supported their recovery (Borg and Kristiansen, 2004, Light and Tse, 2006). These insights from the service user perspective on what helps their recovery can then be used to identify future areas for staff development (Topor and Denhov, 2014).

The conceptual framework practice domain of Promoting Citizenship highlights the responsibility of the mental health system to promote recovery at a societal level, and because recovery occurs in the community and not in the clinic, it may have the highest potential for health gain. Citizenship-orientated interventions and initiatives are needed. Research to address the capacity of the mental health workforce to provide socio-political support is also needed. For example, the ability of staff to manage and balance the tensions between individual choice and control, and the practice of compulsion and managing risk.

Co-production is also emerging as a powerful way to support the active participation of individuals who use services and values equal partnership working between staff and service users in delivering outcomes that are negotiated and agreed collaboratively. Beck and colleagues (2015) suggest that co-production can lead to a wiser and more compassionate organisation (Beck et al., 2015). Research on how to successfully support the integration of co-production into mental health services is needed alongside effectiveness studies. A participatory approach to research would support the co-production model by addressing the asymmetrical power relationship in traditional research design (Sweeney et al., 2012, Kidd et al., 2015).

2. The impact of service-defined recovery on service efficiency and health gains

The outcome and resource implications of service-defined recovery are unknown, so cost-effectiveness studies are a priority for future research. The value for money offered by service-defined recovery, both in relation to health gains for service users and service efficiency, is an important knowledge gap. A recent report from The King's Fund (2016) argues for sustained commitment to quality improvement, and states: *'By quality improvement we mean designing and redesigning work processes*

and systems that deliver health care with better outcomes and lower cost...This ranges from redesigning how teams deliver care in the clinical microsystems that make up health care organisations to large-scale reconfigurations of specialist services...It includes redesign of training, budgeting processes and information systems and requires leadership and cultures that both understand and value quality improvement' (p.3) (Ham et al., 2016). A comparative analysis could also be conducted to assess differences in the cost-effectiveness of the three different types of recovery-orientated practice. Clinical recovery may be a financially unsustainable approach, with increasing expectations, higher morbidity and reduced resources (Naylor et al., 2016). Personal recovery promotes self-management which may lead to reduced service need and hence cost savings (Repper et al., 2013b). A recent request for researchers to be explicit as to which type of recovery is being investigated has been made (Morera et al., 2016).

7.5 Thesis contribution to knowledge

The need for this thesis was built on three influences: i) the need for mental health services to support recovery, ii) the need for staff perspectives and iii) the author's interest in clinical reasoning. The evidence presented in this thesis has directly addressed knowledge gaps. Overall, three useable and valuable contributions to knowledge have been made for use in both future clinical and research applications.

1. The conceptual framework of recovery-orientated practice (reported in Chapter 3): International best practice in supporting recovery was identified and the key features were translated into service characteristics which highlight the need to promote recovery at a societal level (promoting citizenship), an organisational level (organisational commitment) and an individual level (supporting personally defined recovery and working relationship).

In terms of use, the need to support recovery at multiple system levels means that the conceptual framework offers a structure for locating recovery interventions within the system. For example, the conceptual framework is used by the Implementing Recovery through Organisational Change (ImROC) programme (www.imroc.org) that focuses on organisational transformation and locates interventions in the organisational commitment practice domain (Sainsbury Centre for Mental Health, 2009). The conceptual framework has also been proposed as a structure to re-orientate evidence-based practice. For example, Gordon & Ellis (2013) links

consumer perspectives to the characteristics of the Supporting Personally Defined Recovery practice domain and states: *'Given that consumer recovery is now the official goal of many mental health services around the world, it follows that EBP must be developed within this framework'* (P.11) (Gordon and Ellis, 2013). The conceptual framework provides a foundation for structuring local guidelines and policy (Shepherd, 2008). For example, the conceptual framework of recovery-orientated practice underpins the Australian national framework (Australian Health Ministers' Advisory Council, 2013). The conceptual framework provides a structure for benchmarking recovery-orientated practice (e.g. a basis for developing measures, associated quality indicators, and a framework for supporting staff development within existing practice competencies). For example, the conceptual framework of recovery-orientated practice informed the conceptual underpinning of a new measure of staff support for recovery in mental health (INSPIRE) (Schon et al., 2015, Williams et al., 2015). As of 20 July 2016 and according to the web of science, the conceptual framework of recovery-orientated practice publication (Le Boutillier et al., 2011) has been cited 75 times.

2. The grounded theory of staff perspectives on supporting recovery (reported in Chapter 4 and Chapter 5): The grounded theory of staff perspectives on supporting recovery identified the competing priorities staff experience in relation to recovery-orientated practice and generated new theory to underpin recovery-related research.

3. The systematic review and narrative synthesis of staff understanding of recovery-orientated practice (reported in Chapter 6): The systematic review of staff understanding of recovery as applied to practice makes visible a previously implicit translation of recovery within mental health services, by identifying the concept, service-defined recovery.

The three staff conceptualisations of recovery-orientated practice provide a framework for assessing the effectiveness of the mental health system in implementing recovery orientation and could be used to guide the development and accreditation of services towards a recovery-orientated approach.

In terms of knowledge mobilisation, the systematic review and narrative synthesis publication titled 'Staff understanding of recovery-orientated mental health practice: a systematic review and narrative synthesis' was reviewed and published in a

weblog post by the National Elf Service in August 2015

(<http://www.nationalelfservice.net/mental-health/staff-understanding-of-recovery-orientated-mental-health-practice-a-critical-note-of-caution/>).

7.5.1 Integration into the REFOCUS programme

The REFOCUS programme of research is one example of the way in which the thesis contributions to knowledge may be used. The aim of the REFOCUS programme was to understand how, and to increase the extent to which mental health services can promote recovery. REFOCUS was structured around the MRC Framework for Complex Interventions, which recommends systematic development of complex interventions using a clear theoretical basis (Craig et al., 2008). The objectives (detailed in Chapter 1) are restated here to demonstrate how the thesis findings contributed to, and informed the wider REFOCUS programme:

1. To identify gaps between current and recovery-orientated practice and to understand why those differences exist
2. To develop a manualised and empirically defensible complex intervention to support recovery, based on an explicit and testable model
3. To identify or develop appropriate patient-level process and outcome measures
4. To evaluate the intervention in a randomised controlled trial.

Developing the intervention

The findings of the conceptual framework of recovery-orientated practice (reported in Chapter 3) influenced the development of the REFOCUS intervention in two ways. First, the conceptual framework provided a theory foundation for the REFOCUS intervention and was used as an organising framework (Slade et al., 2015b). This was achieved by grouping candidate interventions into each of the four conceptual framework practice domains when evaluating them for feasibility (Bird et al., 2014c, van der Krieke et al., 2015). The resulting REFOCUS intervention has two components, targeting the Working relationship and the Supporting personally defined recovery practice domains (Bird et al., 2011, Bird et al., 2014a). Second, the conceptual framework was used to make explicit the practice domains not addressed in the REFOCUS intervention (i.e. Organisational commitment and Promoting citizenship practice domains), providing direction for future research.

The findings of the grounded theory study of staff perspectives on supporting recovery (reported in Chapter 4 and Chapter 5) influenced the development of the REFOCUS intervention in two ways. First, the grounded theory study found that staff conceptualisations of recovery-orientated practice consistently under-emphasised the role of service users as active partners and made little reference to either the expectations of people using services, or to using "lived experience" as a recovery resource. Because both parties are active agents in the relationship, the REFOCUS intervention tried to raise expectations in service users about being actively involved in the working relationship, and encouraged them to bring their expertise by experience to inform the clinical discussions. Second, to promote equal partnership and to introduce the model of co-production, resources were made available for staff and service users to undertake a Partnership Project of their choice.

Implementation

The findings of the grounded theory study of staff perspectives on supporting recovery influenced the development of the REFOCUS implementation strategy in seven ways. First, staff reported a range of opinions about recovery orientation that reflected their need to balance competing priorities and demands placed on them. Staff training in the REFOCUS intervention was delivered to teams so a development of a shared team understanding was included as a training goal. Second, staff values were found to underpin practice and Staff Role Perception was identified as influential in both the grounded theory and the narrative synthesis of included review papers, so another goal of staff training was to give a safe opportunity to explore values held by individual workers. Third, staff values were included as influences on the final REFOCUS model (causal pathway from receiving the intervention to improved support for recovery, shown in Figure 7.5) having been identified as important implementation factors in the grounded theory and narrative synthesis.

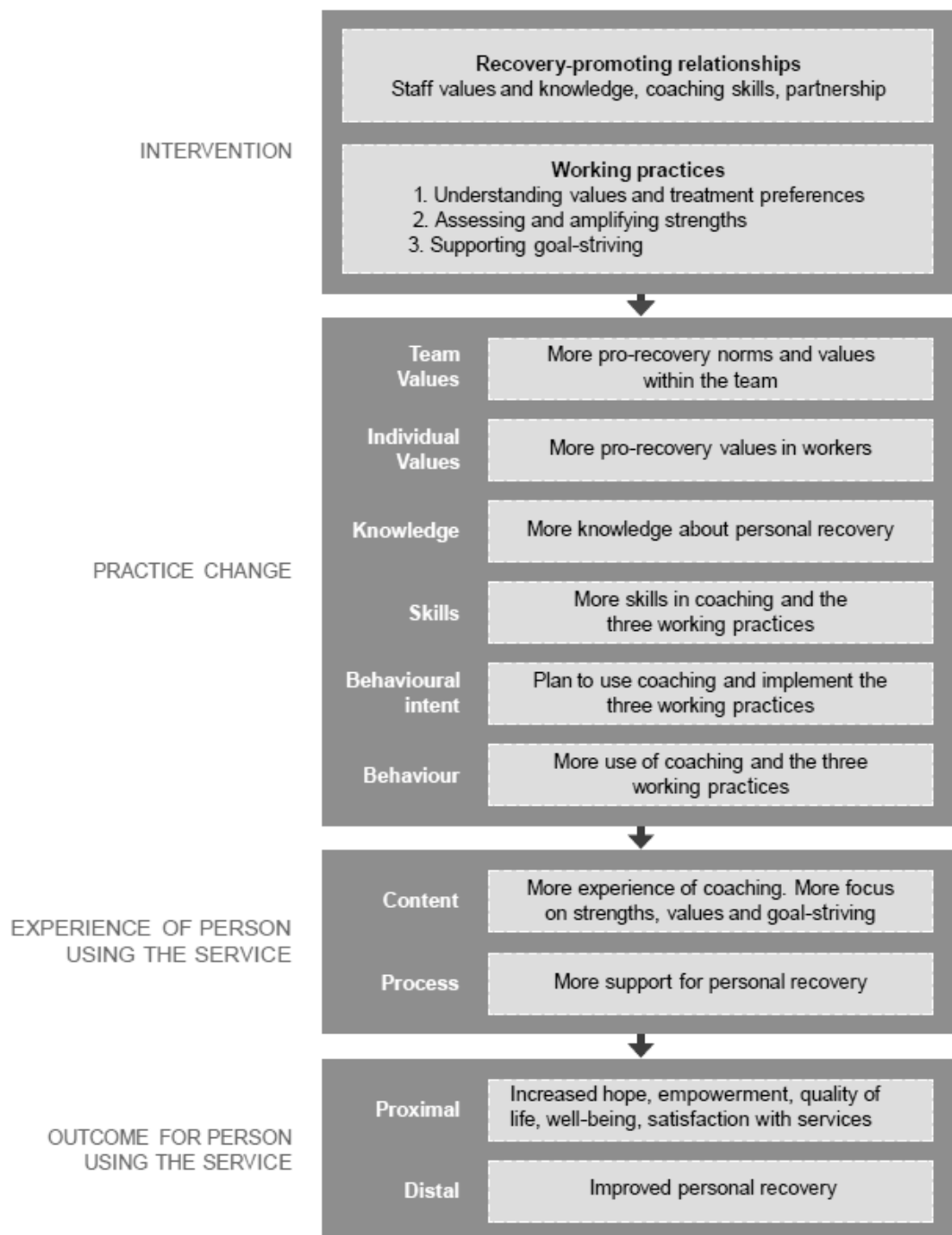


Figure 7.5 REFOCUS Model

Fourth, to promote awareness of the study and to raise expectations for service users to be involved in their own care (because the role of service users in their recovery was consistently under-emphasised in staff conceptualisations of recovery-orientated practice), information about the study (posters, letters etc) and the need to raise expectations was available for service users at all CMHT sites. Fifth, meetings were held with staff and service users as another example of partnership working and to continue to share information and raise expectations. Sixth, the

training sessions for staff were delivered in partnership with individuals who live with mental illness, to continue to promote the expectations of staff and service users and to use "lived experience" as a recovery resource. Seventh, staff reported that they needed protected working time to be able to support recovery so reflection sessions for teams, team leader reflection meetings and reflection in individual staff supervision were included in an attempt to prioritise recovery.

Evaluating the intervention

The findings from this thesis influenced the evaluation of the intervention in two ways. First, as discussed in Chapter 6, the conceptual framework of recovery-orientated practice was used to support the conceptual underpinning of a new measure called INSPIRE, which has sub-scales assessing the value placed on the Support received (Supporting Personally Defined Recovery) and the Relationship with the worker (Working Relationship) (Williams et al., 2015). Second, the emerging data from the grounded theory study informed the process evaluation. Individual interview schedules and a team-level focus group topic guide were designed to address individual and wider contextual factors which might promote or inhibit staff efforts to implement the REFOCUS intervention (Moore et al., 2015).

7.6 Conclusion

The quality of health service provision remains paramount (Department of Health, 2014, NHS England et al., 2014) and national mental health policy identifies personal recovery as the intended orientation of mental health services (Department of Health, 2011). The thesis indicates that a shift from the dominant clinical recovery paradigm to personal recovery is underway, but not complete. The thesis identified three conceptualisations of recovery support: Personal Recovery, Clinical Recovery and Service-defined Recovery. Organisational priorities influence how staff understand recovery-orientated practice, so service-defined recovery will influence the delivery, management and evaluation of recovery-orientated practice. This new understanding of recovery is consistent with concerns raised by people who use mental health services about the misuse of recovery to meet service demands which do not align with the priorities of service users (Beresford et al., 2016) and focus on organisational goals rather than their own (Rose, 2014). Overall, there is a discrepancy between the organisational endorsement and expressed intent to promote recovery-orientated practice on the one hand, and the capacity of services and practitioners to operationalise the concept in day-to-day work on the other. Addressing this dissonance will involve the development of professional

expectations around recovery-orientation as a primary focus for staff. Concrete examples of what recovery means in practice will help, and existing clinical skills in managing competing priorities need protection. However, only when a shared understanding and unified approach exists across all levels of the mental health system will the vision of recovery orientation be closer to being fully implemented.

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Appendix 2 Conceptual framework of Recovery-orientated Practice: Full coding framework

Practice Domain 1: Promoting Citizenship

1.1 Seeing beyond "service user"

1.1.1 Challenge discrimination, stigma and inequality

1.1.1.1 Promote mental well-being in the community

1.2 Service user rights

1.2.1 Advocacy

1.3 Social inclusion

1.3.1 Housing support

1.3.2 Social network

1.3.3 Community integration

1.3.3.1 Community opportunities

1.4 Meaningful occupation

1.4.1 Valued life roles and social roles

1.4.1.2 Identity

1.4.1.2.1 Spirituality

1.4.1.2.2 Giving back to others

1.4.1.2.3 Employment and training

Practice Domain 2: Organisational Commitment

2.1 Recovery vision

2.2 Workplace support structures

2.2.1 Leadership

2.2.2 Policies and procedures

2.3 Quality improvement

2.3.1 Services are directed by and responsive to service users, families and carers

2.3.2 Routine evaluation and service improvement

2.4 Care pathway

2.4.1 Service accessibility

2.4.1.1 Location and physical environment

2.4.1.2 Continuity of care

2.4.1.3 Long-term commitment

2.4.2 Inter-agency working

2.5 Workforce planning

2.5.1 Workforce diversity representative of community it serves

2.5.2 Recruitment guided by recovery values

2.5.3 Staff support

2.5.3.1 Staff knowledge, skills and values

2.5.3.1.1 Lifelong learning and reflective practice

2.5.3.1.2 Evidence based practice

2.5.3.1.3 Supervision and appraisal

2.5.3.2 Staff health and wellbeing

2.5.3.2.1 Foster hope and optimism in staff

Practice Domain 3: Supporting Personally Defined Recovery

3.1 Individuality

3.1.1 Empowerment and self-determination

3.1.2 Personalisation

3.2 Informed choice

3.2.1 Access to information and options

3.2.2 Personal choice

3.2.3 Shared decision-making

3.2.4 Goal striving

3.2.4.1 Goal attainment

3.2.4.2 Celebrate achievements

3.2.5 Positive risk taking

3.2.5.1 The right to make mistakes

3.3 Peer support

3.3.1 Self-management

3.3.1.1 Access to resources

3.3.2 Recovery narratives

3.4 Strengths focus

3.4.1 Natural supports

3.5 Holistic approach

3.5.1 Wellness and crisis planning

3.5.1.1 Mental well-being

3.5.1.2 Physical well-being

3.5.1.3 Dual diagnosis

3.5.1.4 Medication

3.5.1.5 Psychological therapies

3.5.1.6 Alternative therapies

3.5.1.7 Advance directives

3.5.2 Care co-ordination

Practice Domain 4: Working Relationship

4.1 Partnerships

4.1.1 Service user independence and autonomy

4.1.1.1 Respect and value people as individuals

4.1.2 Work creatively

4.1.2.1 Support stages of engagement

4.1.2.2 Promote risk self-management

4.1.2.3 Reduce coercion

4.2 Inspiring hope

4.2.1 Service user primacy

4.2.2 Value and believe in service user

Appendix 3 COREQ checklist used to report grounded theory

Item number	Descriptor	Reported on page number
1	Interviewer/facilitator: Which author/s conducted the interview or focus group?	81,84
2	Credentials: What were the researcher's credentials? E.g. PhD, MD	13
3	Occupation: What was their occupation at the time of the study?	16
4	Gender: Was the researcher male or female?	16
5	Experience and training: What experience or training did the researcher have?	13,16
6	Relationship established: Was a relationship established prior to study commencement?	90
7	Participant knowledge of the interviewer: What did the participants know about the researcher? E.g. personal goals, reasons for doing the research	90
8	Interviewer characteristics: What characteristics were reported about the interviewer/facilitator? E.g. bias, assumptions, reasons and interests in the research topic	90
9	Methodological orientation and theory: What methodological orientation was stated to underpin the study? E.g. grounded theory	18,70
10	Sampling: How were participants selected? E.g. purposive, theoretical	77,82
11	Method of approach: How were participants approached? E.g. face-to-face, telephone, email	77,79,83
12	Sample size: How many participants were in the study?	94
13	Non-participation: How many people refused to participate or dropped out? Reasons?	X
14	Setting of data collection: Where was the data collected? E.g. clinic, work place	79,84
15	Presence of non-participants: Was anyone else present besides the participants and researchers?	81
16	Description of sample: What are the important characteristics of the sample? E.g. demographic data, date	95
17	Interview guide: Were questions, prompts, guides provided by the authors? Was it pilot tested?	79,84
18	Repeat interviews: Were repeat interviews carried out? If yes, how many?	84
19	Audio/visual recording: Did the research use audio or visual recording to collect the data?	81,84
20	Field notes: Were field notes made during and/or after the interview or focus group?	90
21	Duration: What was the duration of the interviews or focus group?	79,84
22	Data saturation: Was data saturation discussed?	83
23	Transcripts returned: Were transcripts returned to participants for comment and/or correction?	84
24	Number of data coders: How many data coders coded the data?	92
25	Description of the coding tree: Did authors provide a description of the coding tree?	97
26	Derivation of themes: Were themes identified in advance or derived from the data?	76,79
27	Software: What software was used to manage the data?	86
28	Participant checking: Did participants provide feedback on the findings?	84
29	Quotations presented: Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? E.g. participant number	98
30	Data and findings consistent: Was there consistency between the data presented and the findings?	97
31	Clarity of major themes: Were major themes clearly presented in the findings?	97
32	Clarity of minor themes: Is there a discussion of minor themes?	98

Appendix 4 Focus Group Sampling Information Sheet

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Research Department**
Section for Recovery

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KING'S
College
LONDON

Further information on focus group recruitment and sampling strategy

We would like to run two focus groups: one with team leaders and one with staff. The focus groups will last 90 minutes and will ask participants what factors they think help or hinder the promotion of recovery in NHS community mental health services.

We will include:

- To be eligible the teams need to use the care programme approach (CPA).
- The focus groups will only recruit participants who work in NHS secondary care community Adult Mental Health Services.

We would like to recruit between 6-8 participants for each focus group, using purposive sampling:

- 1) Focus group 1 (Team leaders): We would like to approach all team leaders of NHS community adult mental health services (using CPA).
- 2) Focus group 2 (Staff): We would like to recruit staff of NHS community adult mental health services (using CPA). Staff participants need to have direct clinical contact. A broad sample would be ideal with a spread of staff across teams, professional groups (e.g. STR workers, nurses, psychiatrists, occupational therapists, psychologists, social workers, vocational specialists, care co-ordinators), genders, grades (e.g. bands 2-7) and length of time working in Adult Mental Health services.

Setting:

We would ideally like to hold the focus groups at a community team base. If this is not possible, the focus groups can be held at a voluntary sector team base.

Recruitment:

Staff and team leaders: We will provide information sheets for dissemination and would like to publicise the focus groups to team leaders in the first instance. Team leaders will then be asked to disseminate information sheets to staff team members. Team leaders and staff who would like to participate would then contact either local collaborators or research team members for details on location and times, and to ask further questions.

The research team will be available by email and telephone to answer queries about the focus groups during the recruitment phase.

Appendix 5 Participant Invitation Letter (Focus groups and Interviews)

**Institute of
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LONDON

Clair Le Boutillier
Health Services and Population Research Department
Institute of Psychiatry
Denmark Hill
SE5 8AF
Tel: 020 7848 0690

DATE

Dear

Re: Research Project: REFOCUS Study.

I am writing to invite you to take part in a study which is currently taking place in [INSERT TRUST].

We would like to find out about your experiences of delivering and/or leading services that have been supportive in promoting recovery, and experiences of where you feel services have not been supportive in promoting recovery. This would involve attending [INSERT a focus group for 90 minutes OR an interview for one hour] on [INSERT DATE AND VENUE].

Thank you for taking the time to read this letter. An information sheet about the study, with more detail, is included with this letter. If you are interested in taking part please return the tear off slip at the bottom of this invitation (in the freepost envelope provided), or call me on **020 7848 0690** or email on clair.le_boutillier@kcl.ac.uk

Yours sincerely

Clair Le Boutillier
Research Worker and PhD student – REFOCUS study

I _____ [INSERT NAME] would like to participate in the interview on _____ [INSERT DATE].

My contact details are

[INSERT PREFERRED CONTACT METHOD e.g. postal address/ email address/ telephone contact]

Please return in the freepost envelope provided.

Appendix 6 Focus group Participant Information Sheet

**Institute of
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INFORMATION ABOUT THE RESEARCH

STAFF/TEAM LEADER INFORMATION SHEET

What helps and what hinders recovery-orientated practice in community mental health services

We would like to invite you to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The research will ask about what you think helps community mental health services to promote recovery and what you think hinders community mental health services from promoting recovery. We would like to find out about your experiences of delivering and/or leading services that have been supportive and your experiences of where you feel services have not been supportive in promoting recovery. Our aim is to explore the contextual blocks and enablers of delivering recovery-orientated mental health services.

Why have I been chosen?

We are gathering information from community mental health teams in five NHS Trusts across England. You have been chosen to take part because you are currently working in a community mental health team participating in this study. We will also approach service users and carers to ask them what they think helps or hinders recovery-oriented working.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

You will be invited to attend a focus group with around seven other people who work in mental health services to share your ideas. The focus group will last approximately one

and a half hours and will take place at a local community mental health service site. A focus group is a way to gather experiences of a group of people and offers you the opportunity to share your ideas with other people. The focus group will be led by the research team and will be audio-taped in order to capture all of your experiences accurately. Your responses will remain confidential and you will not be judged on what you have to say.

What do I have to do?

You will be asked to attend a focus group at the community mental health site for approximately one and a half hours. We will ask you about your experience of delivering and/or leading community mental health care and about what you feel has helped and what has got in the way of providing a recovery-oriented service.

What are the possible disadvantages and risks of taking part?

We do not think there will be any disadvantages or risks to you taking part in this study.

What are the possible benefits of taking part?

We hope that your experiences and views will inform what helps and what hinders recovery-oriented practice. This will support people who use services and staff/organisations that deliver services to promote recovery-orientated ways of working in community mental health teams.

What happens when the research study stops?

This study is part of a bigger project, the REFOCUS study, which aims to promote recovery-oriented ways of working in community mental health services. The information collected in the focus group will be used to inform recovery-oriented team quality standards and future recovery-orientated assessments and treatments used in community mental health care.

What if something goes wrong?

The researcher will support you if there is a problem during the focus group.

Will my taking part in this study be kept confidential?

The information you share will be kept strictly confidential. The audio-taped focus groups will be typed up after the session in order to analyse the information. The tape and typed document will be kept secure.

What will happen to the results of the research study?

The results of the study will be published in scientific journals, conferences, and reports to service managers. At no time will you be identified so only the research team will know what you have said. If we use any direct quotes from your focus group, we will remove your name and any identifying information from the quote, so only the research team will know who said what.

Who is organising and funding the research?

The REFOCUS study is funded by the NHS National Institute for Health Research and is led by Dr Mike Slade at the Institute of Psychiatry, King's College London.

Who has reviewed the study?

This study has been reviewed by the Research Ethics Committee.

Contact for Further Information

If you would like any more information about the focus group study please contact:

Clair Le Boutillier
Research Worker
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King's College London
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Thank you for taking part in this study.

Appendix 7 Initial Focus Group Topic Guide

Qualitative study: Building an understanding of recovery-orientated practice in community-based mental health services in England: Staff and team leader perspective

Implementing recovery-orientated practice

Early topic guide

The aim of this study is to investigate and explore the perception of participants regarding recovery-orientated practice in community mental health services. Participants will be encouraged to discuss their opinions, experiences and perceptions in an open way to ensure any issues of importance to the study are not excluded and a diversity of responses are gathered. The study recognises that NHS services are one resource that might support recovery and that some people recover without this support. Other people might use NHS services as a navigator to mainstream/non-mental health community resources that will support their recovery e.g. use of personal health budgets, education/employment services.

The topic guide contains key questions and themes to be explored within each group. Further questioning will fully explore participants' contributions in order to understand how and why views are held. Time spent discussing different themes may vary between groups in response to the discussion generated amongst participants.

Participant information sheet provided in advance. Participants given the opportunity to ask questions, and sign consent form (coffee and biscuits – 15 mins) prior to joining the focus group– provided with name badge.

1. Introduction to focus group and ground rules (7 mins)

Aim: to introduce the research and set the context for the focus group

- **Introduce self** [previous clinical role in NHS – if approp] **and any other researchers/ observers.** Explain why two researchers are present - assisting with organisation of event, taking notes, observing group etc (where applicable)
- **Introduce the study**
The purpose of the study is to find out about your views and experiences of implementing recovery in practice – in NHS community mental health teams. This provides us with information on factors that facilitate or hinder implementation and on possible solutions to overcome any identified barriers. There are 3 core questions that will be covered today.
- **Details about participation**
Voluntary nature of participation – both overall and in relation to any specific questions and discussions
 - Length of group – 1.5 hours. Will finish on time – clock to keep to time
 - Recording of focus group – stop for loud noises
 - Confidentiality and how findings will be reported - anonymity, transcribing
 - Ask people to respect each other's views and confidentiality in focus group
 - Emphasise there is no need to share personal experiences unless people want to.

- Explain that there are no right or wrong answers – interested in a range of views,
- opinions and experiences
- Explain we are interested in what everyone has to say and everyone's view is important
- **Basic ground rules**
 - Mobile phones off (or on silent/vibrate)
 - Consensus not required – diverse range of views and perspectives helpful

“Even if you think your view or experience is just like everyone else's we want to hear your story, because there's always something unique in each person's own experience or opinion. If your experience is a little different from what others are saying then that is exactly when we want to hear from you.”
 - Talking one at a time (recording)
- Any questions?

1. Background (3 mins)

Aim: to introduce synthesis of recovery-orientated practice guidelines/context

- To start, we will provide a brief overview of the context of recovery-orientated practice as defined by this study. (Brief presentation of thematic analysis of recovery-orientated practice – refer to poster. The poster can be used as reference throughout the session to support conversation/prompts if required.)
NB: Remain mindful that this context may be further away that what is currently happening in services.

2. Introductions for participants – Start recording session (5 mins)

Aim: to allow each participant to introduce themselves to the facilitator and the group.

- Our overall aim is to promote recovery-orientated practice in services. Please introduce yourself and tell us one thing that recovery means to you – **take notes of names/seating plan**

3. Understanding implementation of recovery-orientated practice

*Aims: 1) To explore what participants think helps or hinders implementation.
2) To explore what participants identify as potential solutions to implementation barriers.*

4a. What helps implementation? Facilitating factors (25 mins)

Link: We've been hearing about recovery-orientated practice and what recovery means to you, I'd like to start by asking...

- **What helps you and your team to promote recovery?**

Prompts based on the Theoretical Domains Interview (Michie 2005) will support detailed discussion around the barriers and facilitators of implementation based on the listed domains. The list will not be followed in a predetermined order.

- Knowledge: Are you familiar with this approach?

- Skills: Do you know how to work in a recovery-orientated way?
- Social/professional role and identity: Some people say that this approach might challenge professionals' roles and identity. What do you think?
- Beliefs about capabilities: How well equipped or confident are you that you can work in this way?
- Beliefs about consequences: Do you believe that promoting recovery in services is a good thing?
- Motivation and goals: Are there other things that you would like to do or achieve that might interfere with this approach?
- Memory, attention and decision-making processes: Do you think you will have to pay more attention to work in this way and will you remember to do it?
- Environmental context and resources: To what extent do physical or resource factors facilitate or hinder you and your team from promoting recovery?
- Social influences: To what extent do social influences facilitate or hinder you and your team from promoting recovery (peers, managers, other professional groups, service users, carers)?
- Emotional regulation: To what extent do emotional factors facilitate or hinder?

Probe:

- **What can you tell us about that?**
- **Do other people share that view/experience?**
- **What do other people think? What helps?**
- **We're hearing a lot of different elements about what helps XYZ, is there anything else that anyone thinks of, when they think about what helps implementation?**
- **Are there any other factors that help?**
- **Does anyone have a different view to that?**
- **I can see lots of people nodding, what do other people think?**
- **Some people don't seem to agree, what do you think?**
- **Bring it back on topic... Can I ask a question related to that, that I asked at the beginning – what helps you and your team to promote recovery?**
- **Uncertainty of participant in answering question... Which way is most important to you?**
- **Support all to participate – active watching... You looked like you were coming in there**
- **Use non-verbals to bring people into group – direct eye contact, open arm space, looking around group**

4b. What prevents or hinders implementation? Barriers (25 mins)

- **What prevents or hinders you and your team from promoting recovery?**

Prompts based on the Theoretical Domains Interview (Michie 2005) will support detailed discussion around the barriers and facilitators of implementation based on the listed domains. The list will not be followed in a predetermined order.

- Knowledge: Are you familiar with this approach?
- Skills: Do you know how to work in a recovery-oriented way?
- Social/professional role and identity: Some people say that this approach might challenge professionals' roles and identity. What do you think?

- Beliefs about capabilities: How well equipped or confident are you that you can work in this way?
- Beliefs about consequences: Do you believe that promoting recovery in services is a good thing?
- Motivation and goals: Are there other things that you would like to do or achieve that might interfere with this approach?
- Memory, attention and decision-making processes: Do you think you will have to pay more attention to work in this way and will you remember to do it?
- Environmental context and resources: To what extent do physical or resource factors facilitate or hinder you and your team from promoting recovery?
- Social influences: To what extent do social influences facilitate or hinder you and your team from promoting recovery (peers, managers, other professional groups, service users, carers)?
- Emotional regulation: To what extent do emotional factors facilitate or hinder?

Probe:

- **What can you tell us about that?**
- **Do other people share that view/experience?**
- **What do other people think? What hinders?**
- **We're hearing a lot of different elements about what hinders XYZ, is there anything else that anyone thinks of, when they think about what hinders implementation?**
- **Are there any other factors that hinder?**
- **Does anyone have a different view to that?**
- **I can see lots of people nodding, what do other people think?**
- **Some people don't seem to agree, what do you think?**
- **Bring it back on topic... Can I ask a question related to that, that I asked earlier – what hinders you and your team to promote recovery?**
- **Uncertainty of participant in answering question... Which way is most important to you?**
- **Support all to participate – active watching... You looked like you were coming in there**
- **Use non-verbals to bring people into group – direct eye contact, open arm space, looking around group**

4c. Implementation solutions (25 mins)

- **What solutions would you recommend to address these identified barriers?**

Prompts:

- Behavioural regulation: What preparatory steps are needed for you and your team to promote recovery?
- Nature of the behaviour: Who needs to do what differently when, where, how, how often and with whom?

Probes:

- **What about recovery champions?**

- I've heard about X, what do you think?
- *We've just got a couple of minutes left* – the discussion has been really helpful. Does anyone think anything different or want to add anything?

Bring discussion to a close, thank respondents and reiterate confidential nature of group. Any further questions about us or the research? www.researchintorecovery.com
Explain what happens next – involvement in survey/RCT (2gether/SLaM) and when they might next hear from REFOCUS.

Appendix 8 Individual Interview Participant Information Sheet

**Institute of
Psychiatry**

at The Maudsley

Health Service & Population
Research Department
Section for Recovery

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KING'S
College
LONDON

STAFF INFORMATION SHEET

INDIVIDUAL INTERVIEWS

We would like to invite you to take part in a research study. This is part of a wider research project called REFOCUS which aims to make recovery a reality in community-based adult mental health services in England. This part of the project will focus on the experiences of staff members and team leaders on implementing recovery oriented practice in the NHS.

Before you decide if you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The research will ask about what you think helps community mental health services to promote recovery and what you think hinders community mental health services from promoting recovery. We would like to find out about your experiences of delivering and/or leading services that have been supportive and your experiences of where you feel services have not been supportive in promoting recovery. Our aim is to explore the contextual blocks and enablers of delivering recovery-oriented mental health services.

This research is being carried out by a research worker for her Ph.D.

Why have I been chosen?

We are gathering information from community mental health teams in five NHS Trusts across England. You have been chosen to take part because you are currently working in a community mental health team participating in this study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you

decide to take part you are still free to withdraw at any time and without giving a reason. Your decision will not affect your employment in any way.

What will happen to me if I take part?

You will be invited to attend an individual interview with a researcher to share your experiences of barriers and facilitators to implementing recovery oriented practice. The interview will last approximately one hour and will take place at a mental health service location that is convenient for you. The interview will involve an informal discussion with the researcher where you will be offered the opportunity to share your ideas and experiences. The interview will be audio-taped in order to capture all of your experiences accurately. Your responses will remain confidential and you will not be judged on what you have to say.

What do I have to do?

You will be asked to attend an interview at a mental health service location that is convenient for you for approximately one hour. You will be asked about your experience of working in mental health services and about what you think helps community mental health services to promote recovery and what you think hinders community mental health services from promoting recovery.

What are the possible disadvantages and risks of taking part?

We do not think there will be any disadvantages or risks to you taking part in this study.

What are the possible benefits of taking part?

We hope that your experiences and views will inform what helps and what hinders recovery-oriented practice.

What happens when the research study stops?

This study is part of a bigger project, the REFOCUS study, which aims to promote recovery-oriented ways of working in community mental health services. The information collected in the interviews will be used to inform recovery-oriented interventions and implementation in community mental health care.

What if something goes wrong?

The researcher will support you if there is a problem during the interview.

Will my taking part in this study be kept confidential?

The information you share will be kept strictly confidential. The audio-taped interviews will be typed up after the session in order to analyse the information. The tape and typed document will be kept secure.

What will happen to the results of the research study?

The results of the study will be published in scientific journals, conferences, and reports to service managers. At no time will you be identified so only the research team will know what you have said. If we use any direct quotes from your interview, we will

remove your name and any identifying information from the quote, so only the research team will know who said what.

Who is organising and funding the research?

The REFOCUS study is funded by the NHS National Institute for Health Research and is led by Dr Mike Slade at the Institute of Psychiatry, King's College London.

Who has reviewed the study?

This study has been reviewed by the Research Ethics Committee.

Contact for Further Information

If you would like any more information about the interviews please contact:

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Appendix 9 Staff/Team Leader Individual Interview Schedule (Version 1)

STAFF INTERVIEW SCHEDULE

The interview topic guide will focus on learning from success by using practice examples of recovery orientation to identify blocks and enablers to implementation as well as gathering participants' views on incorporating recovery in to their routine clinical practice. The interview will last up to one hour with an additional fifteen minutes to complete consent and respondent demographic data.

Research objectives

These semi-structured interviews explore the experiences of staff on implementing recovery orientated practice.

There are three key research objectives: to explore,

- the experience of implementing recovery orientated practice
- the barriers and facilitators to implementing recovery orientated practice
- the impact of implementing recovery orientated practice

1. INTRODUCTION AND CONSENT

Aim: To introduce the research, clarify the content of the interview, explain confidentiality and gain consent.

- Introduce self, REFOCUS
- Introduce research
- Participation is voluntary and respondent can withdraw at any time either before, during or after the interview
- Explain confidentiality assurances (confidential unless participant reports unsafe practice against code of conduct)
- Recording (to gain accurate record of discussion, allow interviewer to focus on what respondent is saying, only research team will hear it)
- Length (about an hour with breaks if needed)
- Nature of discussion (conversational in style with specific topics to be addressed, following up information given in survey)
- Place of interview (need for private space to conduct the interview)
- Reporting and data storage (no-one identified in final report, data stored securely under Data Protection legislation – can only be used for purpose collected by law, e.g. transcripts kept in locked cabinets, not shared with anyone outside research team.
- Address any questions
- Gain written consent

2. CURRENT CIRCUMSTANCES – SOCIODEMOGRAPHICS FORM

Aim: To gain background information about the respondent.

- gender (male, female)
- age (years)
- education level
- team model of practice (seven team models of practice: assertive outreach, continuing care, early intervention, forensic, support and recovery, rehabilitation, other)
- work role
- core profession (support time and recovery worker, nurse, psychiatrist, occupational therapist, psychologist, social worker, vocational specialist)
- grade
- length of time since qualification
- length of time in current post (years and months)
- length of work experience in mental health services (years and months)
- experience of mental illness (yes, no)

- use of mental health services (yes, no)
- experience of supporting a family member/friend with mental illness (yes, no)

3a. Barriers and facilitators to implementing recovery - individual practice

[20 mins]

START RECORDING

Aim: To explore what level of implementation respondent has experienced, circumstances surrounding implementation, understandings of how and why it happened, as well as how it made the respondent feel.

- Explore experiences of successful implementation (individual practice)

Describe how, and to what extent *you* have been able to implement recovery orientated practice

Prompts:

- *I'd like to start by asking you to describe an example where you have supported a person's recovery*
- *What happened and how*
What was it about [this example] that supported [that person's] recovery?
- *Was it easy to support [that person's] recovery or did anything get in the way? What helped you to support that person's recovery?*
- *Explore why respondent chose to focus on sharing that particular example*

- Explore experiences of unsuccessful implementation (individual practice)

Describe any difficulties *you* have had with implementing recovery orientated practice

Prompts:

- *Can you describe an example where you haven't been able to support a person's recovery? [if No, go to straight to 3b or request another example of success]*
- *What happened and why*
What was it about [this example] that meant you weren't able to support [that person's] recovery? What was it that got in the way?
- *Explore why respondent chose to focus on sharing that particular example*
- *Have you encountered any other problems when working in this way?*

- Any other examples of implementation?

Do you have any other experiences relating to working in a recovery orientated way that you would like to share?

Prompt:

- *In what other ways have your working practice changed in order to support recovery?*

3b. Barriers and facilitators to implementing recovery - team practice

[20 mins]

Aim: To explore what level of implementation respondent has experienced, circumstances surrounding implementation, understandings of how and why it happened, as well as how it made the respondent feel.

- Explore experiences of successful implementation (team practice)

Describe how, and to what extent *your team* has implemented recovery orientated practice

Prompts:

- *Describe an example where your team has supported a person's recovery*

- *What happened and how?
What was it about [this example] that supported [that person's] recovery?*
- *Was it easy to support [that person's] recovery or did anything get in the way? What helped the team to support that person's recovery?*
- *Explore why respondent chose to focus on sharing that particular example*
- Explore experiences of unsuccessful implementation (team practice)

Describe any difficulties your team have had with implementing recovery orientated practice

Prompts:

- *Can you describe an example where your team hasn't been able to support a person's recovery? [if No, go to straight to 4 or request another example of success]*
- *What happened and why?
What was it about [this example] that meant your team wasn't able to support [that person's] recovery? What was it that got in the way?*
- *Explore why respondent chose to focus on sharing that particular example*
- *Has your team encountered any other problems when working in this way?*
- Anything else?

Are there any [other] factors that influence whether or not you or your team are able to support a person's recovery?

- Prompts:*
- knowledge
 - motivation to change
 - permission to work this way
 - competing demands on time
 - competing philosophies
 - team approach
 - organisational commitment

4. Impact [20 mins]

Aim: Explore respondent's perception of the impact of implementing recovery [or not implementing recovery] on themselves and service users, both tangible/measurable impacts as well as psychological or emotional.

What is your overall experience of implementing recovery in practice?

Prompts:

- *How did it make you feel to support a person's recovery? How was the experience for you?*
- *How did it make you feel to be unable to support a person's recovery? How was that experience for you?*

What are your views on implementing recovery in practice?

Prompts:

- *What are your views on the pros and cons of working this way?*
- *Is this a style of working that is accepted by staff?*
- *Is this a style of working that can be used routinely?*
- Respondents perception of impact of implementing recovery

What effect has working to support individual recovery journeys had on you?

- *Probe for impacts on respondent's:*

- professional role/identity
- values/attitude to service users
- relationships with service users
- team culture
- relationships with team members
- supervision practices
- CPA process

- For each of the above, explore:

- the nature of the impact
- extent to which respondent views the impact as significant or not and reasons why
- any change over time in the way these impacts have been experienced and reasons why

What effect has working to support individual recovery journeys had on the service users whom you support?

- Probe for impacts on:

- empowerment
- hopefulness
- partnership
- involvement in decision making
- increased responsibility
- improved recovery

End of interview. Thank respondent and close interview.

Appendix 10 Revised Staff/Team Leader Individual Interview Schedule (version 5)

STAFF INTERVIEW SCHEDULE

The interview schedule will focus on learning from success by using practice examples of recovery orientation to identify blocks and enablers to implementation as well as gathering participants' views on incorporating recovery in to their routine clinical practice. The interview will last up to one hour with an additional fifteen minutes to complete consent and respondent demographic data.

Research objectives

These semi-structured interviews explore the experiences of staff on implementing recovery orientated practice. There are four key research objectives: to explore,

- the understanding of recovery
- the experience of implementing recovery orientated practice
- the barriers and facilitators to implementing recovery orientated practice
- the impact of implementing recovery orientated practice

1. INTRODUCTION AND CONSENT

Aim: To introduce the research, clarify the content of the interview, explain confidentiality and gain consent.

- Introduce self, REFOCUS
- Introduce research
- Participation is voluntary and respondent can withdraw at any time either before, during or after the interview
- Explain confidentiality assurances (confidential unless participant reports unsafe practice against code of conduct)
- Recording (to gain accurate record of discussion, allow interviewer to focus on what respondent is saying, only research team will hear it)
- Length (about an hour with breaks if needed)
- Nature of discussion (conversational in style with specific topics to be addressed, following up information given in survey)
- Place of interview (need for private space to conduct the interview)
- Reporting and data storage (no-one identified in final report, data stored securely under Data Protection legislation – can only be used for purpose collected by law, e.g. transcripts kept in locked cabinets, not shared with anyone outside research team.
- Address any questions
- Gain written consent

2. CURRENT CIRCUMSTANCES – SOCIODEMOGRAPHICS FORM

Aim: To gain background information about the respondent, to explore their staff role and to identify key characteristics of staff that are more likely to implement recovery.

- gender (male, female)
- age (years)
- education level
- *personality characteristics*
- team model of practice (seven team models of practice: assertive outreach, continuing care, early intervention, forensic, support and recovery, rehabilitation, other)
- work role
- core profession (support time and recovery worker, nurse, psychiatrist, occupational therapist, psychologist, social worker, vocational specialist)
- grade
- length of time since qualification

- length of time in current post (years and months)
- length of work experience in mental health services (years and months)
- experience of mental illness (yes, no)
- use of mental health services (yes, no)
- experience of supporting a family member/friend with mental illness (yes, no)

3. STAFF PERCEPTIONS OF RECOVERY [20 mins]

START RECORDING

Aim: To identify how staff frame their practice, without directing the conversation to recovery. To identify if staff frame practice in terms of recovery, without the prompt (people may work in a recovery-orientated way without referring to recovery)

What is it that you hope to achieve in your practice with clients? What are your priorities and goals for practice? What is important?

Aim: To identify how staff understand and define recovery, their views on recovery, whether or not the definition/understanding/view changes during a career trajectory/over time, meaning-in-use, message from whom/source of information, role perception, personal world view

I'd like to ask you to describe an example where you have supported a person's recovery

Prompts:

- *What happened and how*
- *What was it about [this example] that supported [that person's] recovery?*
- *What was it that enabled recovery? practice (tasks) or reasoning (approach) or both*
- *Was it easy to support [that person's] recovery or did anything get in the way? What helped you to support that person's recovery?*
- *Explore why participant chose to focus on sharing that particular example*
- *Have you always worked in this way? Or has the introduction of recovery meant that you have changed the way you practice?*
- *In what ways has your working practice changed in order to support recovery?*

4a. BARRIERS AND FACILITATORS TO IMPLEMENTING RECOVERY – INDIVIDUAL PRACTICE [20 mins]

Aim: To explore what level of implementation participant has experienced, circumstances surrounding implementation, understandings of how and why it happened, as well as how it made the participant feel, explore experiences of successful/unsuccessful implementation.

Describe how, and to what extent you have been able to implement recovery orientated practice

Describe how, and to what extent you have been able to implement the REFOCUS recovery intervention. Who is involved? What was successfully implemented? What problems were encountered? What lessons can be learnt?

Prompts:

- *individual values*
- *knowledge about personal recovery*
- *skills in coaching and the three working practices (understanding individual values, strengths, goal striving)*
- *behavioural intent (plan to use coaching and implement the three working practices)*

- *behaviour (more use of coaching and the three working practices)*

What is it that enables YOU to support recovery?

4b. BARRIERS AND FACILITATORS TO IMPLEMENTING RECOVERY – TEAM PRACTICE
[20 mins]

Aim: To explore what level of implementation respondent has experienced, circumstances surrounding implementation, understandings of how and why it happened, as well as how it made the respondent feel, explore experiences of successful/unsuccessful implementation.

Describe how, and to what extent *your team* has implemented recovery orientated practice

Describe how, and to what extent the REFOCUS recovery intervention is being implemented by *your team*. Who is involved? What was successfully implemented? What problems were encountered? What lessons can be learnt?

Prompts:

- *team values*
- *knowledge about personal recovery*
- *skills in coaching and the three working practices (understanding individual values, strengths, goal striving)*
- *behavioural intent (plan to use coaching and implement the three working practices)*
- *behaviour (more use of coaching and the three working practices)*

Prompts:

- *Describe an example where your team has supported a person's recovery*
- *What happened and how?*
- *What was it about [this example] that supported [that person's] recovery?*
- *Was it easy to support [that person's] recovery or did anything get in the way? What helped the team to support that person's recovery?*
- *Explore why respondent chose to focus on sharing that particular example*

What is it that enables YOUR TEAM to support recovery?

Are there any [other] factors that influence whether or not you or your team are able to support a person's recovery?

End of interview. Thank respondent and close interview.

Appendix 11 Senior Manager Individual Interview Schedule

SENIOR MANAGER INTERVIEW SCHEDULE

The interview will focus on gaining senior manager perspectives on recovery, and explore how the concept is supported at the organisational level. The interview will continue to identify blocks and enablers to implementation by gathering reflections on incorporating recovery in to routine clinical practice. The interview will last up to one hour with an additional fifteen minutes to complete consent and respondent demographic data.

Research objectives

These exploratory interviews will focus on the experiences of senior managers on supporting recovery in practice. There are three key research objectives to explore,

- the understanding of recovery
- the experience of supporting recovery at the organisational level
- the barriers and facilitators to implementing recovery orientated practice

1. INTRODUCTION AND CONSENT

Aim: To introduce the research, clarify the content of the interview, explain confidentiality and gain consent.

- Introduce self and research
- Cue participants into
 - why they have been selected to be interviewed,
 - what the interview will entail (Inform participants that the interview will ask questions on both what happens in the organisation, and what their views are),
 - what I would like to get out of it.
- Participation is voluntary and participant can withdraw at any time either before, during or after the interview
- Explain confidentiality assurances (confidential unless participant reports unsafe practice against code of conduct)
- Recording (to gain accurate record of discussion, allow interviewer to focus on what respondent is saying, only research team will hear it)
- Length (about an hour with breaks if needed)
- Nature of discussion (conversational in style with specific topics to be addressed)
- Place of interview (need for private space to conduct the interview)
- Reporting and data storage (no-one identified in final report, data stored securely under Data Protection legislation – can only be used for purpose collected by law, e.g. transcripts kept in locked cabinets, not shared with anyone outside research team.
- Address any questions
- Request written consent

2. CURRENT CIRCUMSTANCES – SOCIODEMOGRAPHICS FORM

Aim: To gain background information about the respondent, to explore their staff role and to identify key characteristics of staff that are more likely to implement recovery.

- gender
- age
- education level
- team model of practice
- work role
- core profession
- grade
- length of time since qualification
- length of time in current post

- length of work experience in mental health services
- experience of mental illness
- use of mental health services
- experience of supporting a family member/friend with mental illness

INTERVIEW TOPICS AND PROMPTS

[START RECORDING]

Section 1: Understanding and supporting recovery [10mins]

Aim:

To identify senior managers' understanding and perspectives on recovery

TOPIC: UNDERSTANDING AND SUPPORTING RECOVERY

Main question:

- Recovery can be interpreted and understood in many ways, how would you describe it?

Prompts:

- How do you understand recovery?
- In your opinion, how is recovery best supported in practice?
[Explore detail on recovery knowledge, attitudes, values and principles]
- Can you describe how SLAM *[or other NHS org you have worked for]* supports recovery?
- Does the organisation have any recovery initiatives?
- What is the organisation doing to reinforce recovery values and principles in practice? *[Is there anything to reinforce recovery in day-to-day practice?]*
- How do you view your role and the purpose of your job within the organisation?
- What pressures do you face in your work?
- How does recovery fit with your everyday work? *[Is it central to your role?]*
- Is recovery something that you are able to support in your role?
- Are you able to give an example?

Section 2: Barriers and facilitators to supporting recovery [50 mins]

Aims:

To identify organisational priorities and any impact on supporting recovery

To explore existing service design structures that support recovery

To explore experiences of successful/unsuccessful implementation

TOPIC: ORGANISATIONAL PRIORITIES

Main question:

- How would you describe the core business of this organisation?

Prompts:

- What is SLAM's central vision/mission?
- What do you see as the current organisational priorities?
[cost effectiveness [back to work], efficiency savings, innovation, throughput [discharge], contacts, patient activity [caseload size] risk] [Is recovery a priority?]

- What are the fundamental targets that need to be delivered?
[other than contact time, HoNoS, CPA]
- What are the risks to the organisation if targets are not met?
- How central is recovery to organisational priorities?
- Are there any targets around recovery? CQUIN?
- Is recovery additional and offered when all other targets have been met?
- How does recovery fit with the organisational priorities?
- Can you give me (any other) examples of how recovery is supported by the organisation?
- How are organisational priorities informed? What drives the decisions?
- What is it that drives and maintains current practice?
[Influence of commissioning structures and funding priorities]

TOPIC: SERVICE DESIGN/REDESIGN

Main questions:

- Has the introduction of care pathways and/or clinical academic groups enhanced recovery support?
- In your opinion, do any practice models support recovery more than others, e.g. Early Intervention Vs Recovery & Support?

Prompts:

- What is it about the model that facilitates recovery e.g. underlying capacity of staff – staff-SU ratio?
- In your opinion, what (other) existing service design structures support recovery?
- Have you found any challenges in supporting recovery in an established health system?
[Recovery becomes framed in clinical language and clinical systems e.g. risk, crisis, discharge]
- How do you view the role of the workforce in supporting recovery? Is it their primary role to deliver on organisational targets/priorities?
- How can the workforce be adapted to support recovery?
- How do you ensure staff know it's their job to support recovery?
- Is the workforce recruited to support recovery? If so, how?

TOPIC: GAP BETWEEN SYSTEM AND SERVICE USER PRIORITIES

Main question:

- How does the organisation put the priorities of the service user first?

Prompts:

- In your opinion, are there any tensions between your understanding of recovery and the reality of what happens in practice?

End of interview. Thank respondent and close interview

Appendix 12 Focus Group Participant Consent Form

**Institute of
Psychiatry**

at The Maudsley

**Health Service & Population
Research Department**
Section for Recovery

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Centre Number:
Study Number:
Patient Identification Number for this trial:

STAFF/TEAM LEADER CONSENT FORM

What helps and what hinders recovery-orientated practice in community mental health services

Name of Researcher:

Please initial box

1. I confirm that I have read and understand the information sheet dated
☐ (version) for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time,
☐ without giving any reason, without my medical care or legal rights being affected.
3. I agree to take part in the above study. ☐

Name of Staff/Team leader

Date

Signature

Name of Person taking consent
(if different from researcher)

Date

Signature

Researcher

Date

Signature

1 for staff/team leader; 1 for researcher

Appendix 13 Individual Interview Participant Consent Form

**Institute of
Psychiatry**

at The Maudsley

**Health Service & Population
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KING'S
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LONDON

STAFF PARTICIPANT CONSENT FORM

INDIVIDUAL INTERVIEWS

1. I confirm that I have read and understand the information sheet dated 28.05.10 (version 1) for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my employment or legal rights being affected.
3. I agree to take part in the above study.

Name of Staff/Team leader

Date

Signature

Name of Person taking consent
(if different from researcher)

Date

Signature

Researcher

Date

Signature

1 for staff/team leader; 1 for researcher

Appendix 14 Full staff participant characteristics (n=97)

	Mean (SD)	Focus Groups n=65	Interviews n=32
Age (years)		45.43 (8.116)	44.58 (9.344)
Time since Qualified (months)			228.52 (121.139)
Time in Mental Health Services (months)		207.78 (105.496)	209.81 (120.736)
Time in post (months)		50.58 (46.785)	66.84 (66.735)
	n (%)		
Gender			
Male		26 (40.6)	13 (40.6)
Female		38 (58.5)	19 (59.4)
Missing		1 (1.5)	0 (0.0)
Ethnicity			
White British		50 (76.9)	28 (87.5)
White Irish		2 (3.1)	1 (3.1)
White Other		1 (1.5)	2 (6.3)
Black/Black British-African		5 (7.7)	1 (3.1)
Black/Black British-Caribbean		2 (3.1)	0 (0.0)
Black Other		3 (4.6)	0 (0.0)
Asian/Asian British-Other		1 (1.5)	0 (0.0)
Missing		1 (1.5)	0 (0.0)
NHS Trust			
South London and Maudsley NHS Foundation Trust		13 (20.0)	16 (50.0)
2gether NHS Foundation Trust		14 (21.5)	10 (31.3)
Leicestershire Partnership NHS Trust		12 (18.5)	2 (6.3)
Tees, Esk and Wear Valleys NHS Foundation Trust		13 (20.0)	4 (12.5)
Devon Partnership NHS Trust		13 (20.0)	0 (0.0)
Job Role			
Clinician		34 (52.3)	18 (56.3)
Team Leader		31 (47.7)	6 (18.8)
Senior Manager		0 (0.0)	8 (25.0)
Team			
Assertive Outreach		15 (23.1)	1 (3.1)
Early Intervention		12 (18.5)	4 (12.5)
Forensic		0 (0.0)	0 (0.0)
Support and Recovery		32 (49.2)	18 (56.3)
Rehabilitation		2 (3.1)	0 (0.0)
Supported housing		2 (3.1)	0 (0.0)
Management		0 (0.0)	7 (21.9)
Works across teams		2 (3.1)	1 (3.1)

Profession		
Psychiatrist	2 (3.1)	2 (6.3)
Nurse	40 (61.5)	17 (53.1)
Social worker	7 (10.8)	2 (6.3)
Occupational Therapist	9 (13.8)	5 (15.6)
Psychologist	1 (1.5)	2 (6.3)
Associate practitioner	0 (0.0)	1 (3.1)
Vocational Specialist	1 (1.5)	1 (3.1)
Support time and Recovery worker	2 (3.1)	1 (3.1)
Support worker	2 (3.1)	0 (0.0)
Exercise and health practitioner	1 (1.5)	0 (0.0)
Manager (no clinical background)	1 (1.5)	1 (3.1)
Highest Qualification		
NVQ 4	0 (0.0)	1 (3.1)
HND	0 (0.0)	4 (12.5)
Bachelors	0 (0.0)	13 (40.6)
Masters	0 (0.0)	10 (31.3)
PhD	0 (0.0)	2 (6.3)
Missing	65 (100)	2 (6.3)
Grade		
Band 2	1 (1.5)	0 (0.0)
Band 3	2 (3.1)	2 (6.3)
Band 4	0 (0.0)	1 (3.1)
Band 5	6 (9.2)	1 (3.1)
Band 6	17 (26.2)	12 (37.5)
Band 7	2 (3.1)	5 (15.6)
Band 8a	0 (0.0)	2 (6.3)
Band 8b	1 (1.5)	3 (9.4)
Band 8c	0 (0.0)	1 (3.1)
Band 8d	0 (0.0)	1 (3.1)
Consultant	2 (3.1)	2 (6.3)
Professor	0 (0.0)	1 (3.1)
Social Services	2 (3.1)	0 (0.0)
Student	1 (1.5)	0 (0.0)
Missing	31 (47.7)	1 (3.1)

Appendix 15 Grounded Theory of Staff Perspectives on Supporting Recovery: Full coding framework

Core Category: Competing Priorities

- 1.1 *UNDERSTANDING RECOVERY-ORIENTATED PRACTICE*
 - 1.1.1 *Multiple meanings*
 - 1.1.1.1 Conceptual uncertainty
 - 1.1.1.1.1 Difficulty articulating practice examples
 - 1.1.2 *Misunderstanding recovery-orientated practice*
 - 1.2 *TRANSLATING RECOVERY SUPPORT INTO PRACTICE*
 - 1.2.1 *Diverse translations*
 - 1.2.1.1 Recovery initiatives
 - 1.2.1.2 Recovery interactions
 - 1.2.2 *Clash of paradigms*
 - 1.2.2.1 Conflict between recovery values and medical values
 - 1.2.2.1.1 System-centred not person-centred
 - 1.2.2.1.2 Competing agendas
 - 1.2.3 *Professionalising recovery*
 - 1.2.3.1 Operationalised for service use
 - 1.2.4 *Compromises to support recovery*
-

Sub-category: Health Process Priorities

- 2.1 *INDIVIDUALISED SERVICE VERSUS INSTITUTIONALISED SYSTEM*
 - 2.1.1 *Hierarchy, medical language and clinical tasks*
 - 2.1.1.1 Psychiatric power
 - 2.1.1.2 Recovery competes with core medical tasks
 - 2.1.2 *Focus on problems, diagnosis and symptoms*
 - 2.1.2.1 Pathways and guideline approach
 - 2.1.2.2 Task focus
 - 2.1.2.3 Tick-box approach to care
 - 2.1.3 *Associated stigma*
 - 2.2 *RISK AND RECOVERY*
 - 2.2.1 *Crisis management dominates*
 - 2.2.1.1 Balancing risk, needs and aspirations
 - 2.2.1.2 Supporting risk within legislative frameworks
 - 2.2.1.3 Organisational support to encourage positive risk taking
-

Sub-category: Business Priorities

- 3.1 *ORGANISATIONAL COMMITMENT*
 - 3.1.1 *Trust leadership*
 - 3.1.1.1 Vision and policies
 - 3.1.1.2 Communicating recovery
 - 3.1.1.2.1 Investing in recovery
 - 3.1.1.2.1.1 Adding value

3.1.2 *Supporting staff*

- 3.1.2.1 Staffing resources
 - 3.1.2.2 Space and time
 - 3.1.2.2.1 Competing demands on time
 - 3.1.2.2.1.1 Protected working time
 - 3.1.2.2.2 Suitable working environment
 - 3.1.2.3 Flow and capacity
 - 3.1.2.3.1 Waiting lists
 - 3.1.2.3.2 Caseload size
 - 3.1.2.3.3 Focus on paperwork
 - 3.1.2.4 Supervision
 - 3.1.2.5 Recovery training
 - 3.1.2.6 Staff wellbeing
 - 3.1.2.7 Recruiting recovery-orientated staff
- ### 3.1.3 *Team approach*
- 3.1.3.1 Leadership
 - 3.1.3.2 Team stability
 - 3.1.3.3 Shared team values
 - 3.1.3.4 Shared caseload

3.2 *ORGANISATIONAL SURVIVAL*

3.2.1 *Contractual objectives take primacy*

- 3.2.1.1 Competing government and commissioning priorities

3.2.2 *Financial stability*

- 3.2.2.1 Maintaining funding priorities and commissioning demands
 - 3.2.2.1.1 Hospital admissions
 - 3.2.2.1.2 Service throughput
 - 3.2.2.1.2.1 Referral processes
 - 3.2.2.1.2.2 Contact targets
 - 3.2.2.1.2.3 Discharge
 - 3.2.2.1.2.4 Employment

3.2.3 *Risk to organisation if targets not met*

- 3.2.3.1 Incongruent commissioning structures
- 3.2.3.2 Competing savings programmes
- 3.2.3.3 Demands of increasing activity targets
- 3.2.3.4 Service restructuring
 - 3.2.3.4.1 Managing and reorganising services
 - 3.2.3.4.1.1 Constantly changing system
 - 3.2.3.4.2 EIS and AOT models support recovery
- 3.2.3.5.2.1 Lowered caseloads
- 3.2.3.5.3 Recovery lacks a practice model

3.3 *QUALITY OR QUANTITY*

3.3.1 *Efficiency and productivity*

- 3.3.1.1 Performance and compliance targets

3.3.2 *Outcomes orientation*

- 3.3.2.2 Recovery as service outcome
 - 3.3.2.2.1 Service user experience or activity targets

Sub-category: Staff Role Perception

4.1 CONCEPTUALISATIONS OF WORK ROLE

4.1.1 *Work task priorities*

- 4.1.1.1 Support recovery or manage risk
- 4.1.1.2 Prioritise 'duty of care'
- 4.1.1.3 Balance statutory demands and fulfil service user priorities
- 4.1.1.4 See beyond traditional roles

4.1.2 *Job value*

- 4.1.2.1 Job or vocation
- 4.1.2.2 Esteem of professional role
- 4.1.2.2.1 'Recovery': threat or opportunity
- 4.1.2.3 Self protection and job protection

4.2 PERSONAL VALUES AND QUALITIES OF STAFF

4.2.1 *Support recovery despite the system*

- 4.2.1.1 Test boundaries
 - 4.2.1.1.1 Break rules
 - 4.2.1.1.2 Comply with service parameters
- 4.2.1.2 Personal experience
 - 4.2.2.2.2 Humanistic relationships
- 4.2.1.3 Professional maturity
 - 4.2.1.3.1 Professional confidence
 - 4.2.1.3.2 Sense of self
- 4.2.1.4 Reflexivity
- 4.2.1.5 Recognise need for change
- 4.2.2 '*Specialist*' knowledge and skills of staff
 - 4.2.2.1 Prioritise person-centred and strengths-based practice
 - 4.2.2.2 Training has led to increased awareness of practice

4.3 EXPECTATIONS OF SERVICE USERS

4.3.1 *Preparedness to change practice*

- 4.3.1.1 New boundaries
 - 4.3.1.1.1 Service user or system leadership
 - 4.3.1.1.2 Empowering service user interactions
- 4.3.1.2 Learning from service users
 - 4.3.1.2.1 Service user involvement
 - 4.3.1.2.1.1 Therapeutic partnerships

4.3.2 *Retaining status quo*

- 4.3.2.1 Maintaining the power imbalance
 - 4.3.2.1.1 Them and us barrier

Appendix 16 ENTREQ checklist used to report systematic review

Item number	Item	Descriptor	Reported on page number
1	Aim	State the research question the synthesis addresses.	112
2	Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).	112
3	Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved).	113
4	Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type).	113
5	Data sources	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists) and when the searches conducted; provide the rationale for using the data sources.	116
6	Electronic Search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits).	115
7	Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies).	116
8	Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).	250
9	Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g., for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development).	121
10	Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).	117
11	Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).	117

12	Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	117
13	Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	136
14	Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software).	116
15	Software	State the computer software used, if any.	119
16	Number of reviewers	Identify who was involved in coding and analysis.	119
17	Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts).	119
18	Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	120
19	Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.	119
20	Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations or the author's interpretation.	125
21	Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	128

Appendix 17 Full systematic review search strategy

Database searches

All the databases searched are listed in Table 1 and were carried out during the week starting the 11th of November 2013.

Databases	
Medline & Medline In Process & Other Non-Indexed Citations	1946 to November 11, 2013
PsycINFO	1806 to November week 1 2013
Embase + Embase Classic	1947 to November week 1 2013
Scopus	1996 to present
International Bibliography of the Social Sciences (IBSS)	1951 to present
British Nursing Index	1994 to present
Applied Social Sciences Index and Abstracts (ASSIA)	1987 to present
Cumulative Index of Nursing and Applied Health Literature (CINAHL)	1981 to present

Table 1: Database searches

The full Medline search strategy can found in Table 2. The search was adjusted as necessary for searching other databases, which use different syntax (e.g. * instead of \$).

Search Strategy (N citations)

Free Text terms (lines 1-59)	
Concept 1	1. "mental illness".mp* (15228) 2. "mental disorder".mp (4559) 3. "mental disease".mp (887) 4. "mental health".mp (109636) 5. (mental adj2 problem\$*).mp (7362) 6. (psychol\$ adj2(health or problem\$ or disorder\$ or illness\$)).mp (11797) 7. (psychiatr\$ adj2 (health or illness\$ or disorder\$ or problem\$ or disability\$)).mp (35820) 8. 1 or 2 or 3 or 4 or 5 or 6 or 7 (162223)
Concept 2	9. recover\$.mp (456131)
Concept 3	10. staff.mp (165643) 11. worker\$.mp (137457) 12. "care coordinator\$.mp (265) 13. personnel.mp (259795) 14. employee\$.mp (46161) 15. clinician\$.mp (126163) 16. professional\$.mp (281093) 17. practitioner\$.mp (104355) 18. provider\$.mp (87199) 19. leader\$.mp (59034) 20. manager\$.mp (31396) 21. physician\$.mp (406659) 22. psychiatrist\$.mp (17197) 23. doctor\$.mp (85146) 24. nurse\$.mp (261441) 25. "occupational therapist\$.mp (3190) 26. "social work\$.mp (20273) 27. psychologi\$.mp (356678) 28. "peer support\$.mp (1507) 29. "vocational specialist\$.mp (13)

	30. volunteer\$.mp (145611)
	31. student\$.mp (188300)
	32. "decision maker\$".mp (6995)
	33. 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 (1970743)
Concept 4	34. mean\$.mp (1512766)
	35. define\$.mp (587686)
	36. comprehen\$.mp (176638)
	37. opinion\$.mp (74212)
	38. view\$.mp (312462)
	39. belief\$.mp (48233)
	40. knowledge\$.mp (419832)
	41. perspective\$.mp (164308)
	42. attitude\$.mp (306610)
	43. discourse\$.mp (8163)
	44. theor\$.mp (449933)
	45. experience\$.mp (659377)
	46. perception\$.mp (288885)
	47. rhetoric.mp (1466)
	48. awareness.mp (82037)
	49. translat\$.mp (218784)
	50. implement\$.mp (224638)
	51. operationali\$.mp (4681)
	52. philosoph\$.mp (40277)
	53. appl\$.mp (1230630)
	54. understand\$.mp (594133)
	55. conceptuali\$.mp (15029)
	56. interpret\$.mp (350788)
	57. value\$.mp (1416604)
	58. behavio\$.mp (1006776)
	59. 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 (6913135)

* .mp searches for keywords in the abstract, title, original title, name of substance word and subject heading word fields.

** \$ searches for variations on a word that are formed with different suffixes. adjn retrieves records that contain search terms within a specified number (n) of words from each other in any order.

Subject Headings, MESH terms or Index terms (Lines 60-79)	
Concept 1	60. Psychiatry/ 61. Stress, Psychological/ 62. Mental Disorders/ 63. Mental Health/ 64. 60 or 61 or 62 or 63 (246237)
Concept 3	65. exp Nursing Staff/ (54214) 66. exp Medical Staff/ (23646) 67. exp Nurses' aides/ (3941) 68. exp Patient care team/ (54396) 69. Nursing, supervisory/ (7948) 70. Caregivers/ (21641) 71. exp Administrative personnel/ (34998) 72. Social work, psychiatric/ (2570) 73. exp Voluntary workers/ (8511) 74. exp Students, health occupations/ (46097) 75. 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 (239128)
Concept 4	76. exp Attitudes/ (269678) 77. Knowledge/ (6921) 78. Awareness/ (14519) 79. 76 or 77 or 78 (287067)

Combining concepts
80. 8 OR 64 (334666)
81. 33 OR 75 (2009373)
82. 59 OR 79 (6913211)
83. 9 AND 61 AND 73 AND 78 (3682)
84. limit 79 to English language (3492)

*/ searches subject headings, MeSH terms and Index terms

**exp expands results to include records about the broader topic and all related topics

Table 2: Full Medline search strategy

Subject Headings, MeSH and Index terms used for other databases are reported in Table 3.

	Concept 1	Concept 2	Concept 3	Concept 4
PsycINFO	Mental Disorders/ Psychiatry/ exp Mental Health/ Psychological , Stress/ Psychopathology/ Abnormal Psychology/	"Recovery (Disorders)"/	exp Health Personnel/ Clinicians/ exp Physicians/ Nursing/ exp Social Workers/ Caregivers/ Volunteers/ Medical Students/ Nursing Students/	exp Meaning/ Comprehension/ exp Attitudes/ Declarative Knowledge/ exp Concept Formation/ Theories/ Perception/ Rhetoric/ Awareness/ Theoretical Interpretation/ Organizational Behavior/
Embase	mental disease/ psychiatry/ exp mental health/	n/a	exp health care personnel/ nursing/ caregivers/ volunteer/ exp student/ exp social worker/	comprehension/ exp attitude/ exp knowledge/ concept formation/ awareness/
Cinahl	MH ("Mental Health") MH ("Mental Disorders")	MH (Recovery)	MH ("Mental Health Personnel+") MH ("Personnel, Health Facility+") MH ("Nurses+") MH ("Nurse Managers+") MH ("Psychiatrists") MH ("Physicians") MH ("Occupational Therapists") MH ("Expert Clinicians+") MH ("Health Personnel, Unlicensed") MH ("Volunteer Workers") MH ("Students+") MH	MH ("Work Experiences") MH ("Knowledge+") MH ("Attitude+") MH ("Program Implementation")

			("Social Workers") MH ("Physicians, Family")	
IBSS	su.Exact("psychiatry" OR "mental health" OR "mental illness" OR "psychopathology" OR "psychiatric disorders")	su.Exact("recovery")	(su("nurses" OR "students" OR "physicians" OR "decision makers" OR "providers" OR "psychiatrists" OR "hospital staff" OR "volunteers" OR "doctors" OR "medical personnel" OR "nursing" OR "psychologists")	((su.Exact("beliefs" OR "implementation" OR "behaviour" OR "understanding" OR "perspectives" OR "rhetoric" OR "meaning" OR "opinions" OR "interpretation") OR su("attitudes"))
British Nursing Index	su.Exact("mental health" OR "psychiatric disorders"))	n/a	su("nursing" OR "nurses"))	su("attitudes"))
ASSIA	su.Exact("psychiatry" OR "mental health" OR "abnormal psychology" OR "psychological disorders" OR "mental illness" OR "psychiatric disorders"))	su.Exact("recovery"))	su("nurses" OR "occupational therapists" OR "students" OR "volunteers" OR "peer support" OR "community health workers" OR "clinicians" OR "psychologists" OR "medical staff" OR "providers" OR "doctors" OR "medical personnel"))	(su.Exact("beliefs" OR "implementation" OR "meaning" OR "opinions" OR "interpretation" OR "declarative knowledge") OR su("attitudes"))
Scopus	n/a	n/a	n/a	n/a

Table 3: Subject Headings, MeSH and Index terms used for other databases

Appendix 18 Systematic Review Included Papers (n=22)

	Full reference
1	Aston V & Coffey M (2012) Recovery: what mental health nurses and service users say about the concept of recovery. Journal of Psychiatric and Mental Health Nursing, 19 (3), 257-263.
2	Gilbert H, Slade M, Bird V, Oduola S & Craig TKJ (2013) Promoting recovery-oriented practice in mental health services: a quasi-experimental mixed-methods study. BMC Psychiatry, 13 (1), 167
3	Tickle A, Brown D & Hayward M (2014) Can we risk recovery? A grounded theory of clinical psychologists' perceptions of risk and recovery-oriented mental health services. Psychology and Psychotherapy: Therapy, Research and Practice, 87, 96-110.
4	Turton P, Wright C, White S, Killaspy H & the DEMoBinc Group (2010) Promoting Recovery in Long-Term Institutional Mental Health Care: An International Delphi Study. Psychiatric Services, 61 (3), 293-299.
5	Felton BJ, Barr A, Clark G & Tsemberis SJ (2006) ACT Team Members' Responses to Training in Recovery-Oriented Practices. Psychiatric Rehabilitation Journal, 30 (2), 112-119.
6	Sullivan WP & Floyd DF (2013) Spirit Lifting: Hope and Recovery in Case Management Practice. Families in Society: The Journal of Contemporary Social Services, 94 (1), 38-44.
7	Sullivan WP & Floyd DF (2012) There's More Than Meets the Eye: The Nuances of Case Management. Journal of Social Work in Disability and Rehabilitation, 11 (3), 184-196.

	Full reference
8	Rice EI (2009) Schizophrenia, Violence and Case Management: Being Supportive and Overwhelmed. <i>Psychiatric Rehabilitation Journal</i> , 32 (4), 313-315.
9	Watson MK, Bonham CA, Willging CE & Hough RL (2011) "An Old Way to Solve an Old Problem": Provider Perspectives on Recovery-Oriented Services and Consumer Capabilities in New Mexico. <i>Human Organization</i> , 70 (2), 107-117.
10	Rogers JA, Vergare MJ, Baron RC & Salzer MS (2007) Barriers to Recovery and Recommendations for Change: The Pennsylvania Consensus Conference on Psychiatry's Role. <i>Psychiatric Services</i> , 58 (8), 1119-1123.
11	Dunlap DJ (2009) Social Workers' Experience of Creating and Implementing the Mental Health Discharge Plan within a Recovery Perspective. Dissertation abstracts international section A. <i>Humanities and Social Science</i> , 70 (4-A), 1427.
12	Courtney M & Moulding NT (2013) Beyond Balancing Competing Needs: Embedding Involuntary Treatment Within a Recovery Approach to Mental Health Social Work. <i>Australian Social Work</i> , 67 (2), 214-226.
13	Van Lith T, Fenner P & Schofield MJ (2009) Toward an understanding of how art making can facilitate mental health recovery. <i>Australian e-Journal for the Advancement of Mental Health</i> , 8 (2), 183-193.
14	Cleary M, Horsfall J, O'Hara-Aarons M & Hunt GE (2013) Mental health nurses' views of recovery within an acute setting. <i>International Journal of Mental Health Nursing</i> , 22 (3), 205-212.
15	Hungerford C & Kench P (2013) The perceptions of health professionals of the implementation of Recovery-oriented health services: a case study analysis. <i>Journal of Mental Health Training, Education and Practice</i> , 8 (4), 208-218.

	Full reference
16	Battersby L & Morrow M (2012) Challenges in Implementing Recovery-Based Mental Health Care Practices in Psychiatric Tertiary Care. <i>Canadian Journal of Community Mental Health</i> , 31 (2), 103-117.
17	Schwartz R, Estein O, Komaroff J, Lamb J, Myers M, Stewart J, Vacaflor L & Park M (2013) Mental Health Consumers and Providers Dialogue in an Institutional Setting: A Participatory Approach to Promoting Recovery-Oriented Care. <i>Psychiatric Rehabilitation Journal</i> , 36 (2), 113-115.
18	Kidd SA, McKenzie K, Collins A, Clark C, Costa L, Mihalakakos G, & Paterson J (2014) Advancing the Recovery Orientation of Hospital Care Through Staff Engagement With Former Clients of Inpatient Units. <i>Psychiatric Services</i> , 65 (2), 221-225.
19	Piat M & Lal S (2012) Service Providers' Experiences and Perspectives on Recovery-oriented Mental Health System Reform <i>Psychiatric Rehabilitation Journal</i> , 35 (4), 289-296.
20	Ng R, Pearson V & Chen EYH (2008) What does recovery from schizophrenia mean? Perceptions of psychiatrists. <i>International Journal of Culture and Mental Health</i> , 1 (1), 73-84.
21	Kaewprom C, Curtis J & Deane FP (2011) Factors involved in recovery from schizophrenia: A qualitative study of Thai mental health nurses. <i>Nursing and Health Sciences</i> , 13 (3), 323–327.
22	Cone E & Wilson L (2012) A study of New Zealand occupational therapists' use of the recovery approach. <i>New Zealand Journal Of Occupational Therapy</i> , 59(2), 30-35.

Appendix 19 Systematic Review Data Extraction Table

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
1	857	ASTON2012	UK	Focus groups were used to investigate what staff and service users say about the concept of recovery. The topic guide included questions like “what does the word recovery mean to you?” and “what do you think it would take for a recovery approach to work in local mental health services?” Inductive analysis was undertaken using Framework.	There were two focus groups; one with service users (N=6) and one with in-patient mental health nurses (N=5). Data from the service user and staff focus groups were kept separate during the analysis so that they could be compared.	Four central themes emerged: 1) understanding of recovery The different meanings are described and a need for a shared understanding in order for recovery-orientated services to be delivered is argued. 2) semantics (the use of language to describe the processes of recovery) Describes alternatives to the term ‘recovery’ suggested by participants. 3) therapeutics (relationships between nurses and patients)	6/18 Low quality Conclusions are not grounded in the data. Reflexivity, and auditability not addressed.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
						<p>Describes the difficulties nurses have with providing recovery support, such as not having enough time and being more familiar with task-oriented routines. Nurses also appeared to view recovery support as something they do to patients, rather than a collaborative process.</p> <p>4) [recovery as] a journey.</p> <p>Finally, both groups viewed recovery as "a journey", not something that it is a quick fix but something that is a long and winding road.</p>	
2	6873	GILBURT2013	UK	Pre-post quasi-experimental (mixed methods) design. Within the study, semi-	Semi-structured interviews were carried out with 16 team leaders in the intervention	Nine themes emerged from the interviews; five related to the perception and	<p>9/18 = Mid quality</p> <p>Detailed sample of interview participants not provided.</p>

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				structured interviews were conducted with a sample of the training intervention group to assess their understanding of recovery and its implementation. Transcripts were analysed with inductive coding.	teams. The participating service providers were all working in community-based and in-patient rehabilitation adult mental health teams in the London boroughs of Lambeth, Southwark and Lewisham.	provision of recovery-oriented care (care provision, the role of hope, the language of recovery, ownership and the need for multi-disciplinarity) and four related to its implementation (hierarchy, training, measures of recovery and resources). The researchers note that interviewees' accounts often reflected a struggle to define recovery.	Research limitations regarding qualitative component not addressed. Reflexivity, ethics and auditability not addressed.
3	Expert	TICKLE2012	UK	Grounded theory study using semi-structured interviews to explore the views of clinical psychologists towards the concepts of "risk" and "recovery."	11 clinical psychologists working in adult MHS within two NHS trusts were recruited. Five worked within community mental health teams, two in specialist	The four overarching descriptive categories were 1) Influences (resources, service models and beliefs about what is helpful for service users)	11/18 = Mid quality Sample design not reported. Detailed analysis including exploration of diverse and negative cases.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				Three broad questions led the interviews: views on what constitutes risk, views on what constitutes recovery and how the concepts of risk and recovery might relate to each other. The analysis was inductive, beginning with codes that were close to the data. Codes became more focused as they were synthesised across transcripts and put into descriptive categories. Finally, categories were raised to theoretical concepts to describe relationships between	psychological services, one in rehabilitation services, one in acute mental health services, and two across multiple mental health services.	2) stakeholders 3) working with risk 4) the meaning of recovery. The three theoretical categories were a) Changing cultures in mental health services (e.g. emergence of recovery, increased accountability and blame, move away from paternalistic approaches) b) dominant and marginalised concerns (e.g. risk of harm, fear of blame vs. benefits of recovery, learning from incidents) c) professional conflicts and dilemmas (e.g. wanting to support service users vs. wanting to promote independence or	

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				categories.		wanting to increase responsibility of service user vs. awareness of professional accountability). The authors conclude that the clinical psychologists studied are aware of the emergence of recovery-orientated approaches but feel unable to incorporate them in practice because of perceptions of being bound by both their own limitations and those of their circumstances including issue of risk, thus giving rise to dilemmas in professional practice.	
4	7634	TURTON2010	EUROPE	Three round Delphi consultation. 1) Participants were	Four separate expert groups (staff, advocates, service users and	A total of 4,098 items were generated, of which 3,178 were rated as	12/18 = Mid quality Quality of method not fully captured by the

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				asked to list 10 items which “most helps recovery for people with long-term mental health problems in institutional care” 2) Respondents had to rate the items generated in the first round 3) Respondents had to rate the items again in light of feedback from the way the items were generated in round 2. Items with high ratings and within-group consensus were grouped into themed domains by the researchers. Domains with at least one item rated as essential with 100% group consensus were compared across	carers) across 10 different European countries took part. Participants were known to have a recovery-orientation in institutional settings. Data collection and analysis between stakeholders was kept separate.	essential with at least 80% within group consensus. The items were grouped into 11 broad domains: 1) social policy, human rights and advocacy 2) social inclusion 3) self-management and autonomy 4) therapeutic interventions 5) governance 6) staffing 7) staff attitudes 8) institutional environment 9) meeting needs after discharge 10) involvement of caregivers 11) physical health care. Therapeutic interventions had the most consensus across the countries amongst staff, which	qualitative appraisal checklist. Diverse sample – although aim to achieve consensus. Aimed to keep original wording of items close to participants’ language. Discussion of weaknesses of some of the items.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				stake holder groups and countries.		suggests a more clinical model of recovery (this domain scored high across all stakeholder groups). There were few differences between the stakeholder groups, although staff put a low emphasis on factors related to staffing issues and post discharge support compared to other groups.	
5	4833	FELTON2006	USA	Process evaluation of recovery principles and practices training. Two researchers observed the training sessions and took notes. Any input from a trainee (ACT staff) that directly challenged or endorsed a	A total of 212 multi-disciplinary staff from 18 different agencies attended at least one training session. There was a total of 99.5 hours of training which took place and was observed between June and December 2004.	205 trainee inputs were identified during the training sessions. Inputs fell into one of ten categories describing endorsement of or difficulties with recovery-orientated practice 1) Who is eligible for wellness	13/18 = High quality Good coverage - two researchers attended the sessions and after attending 26 hours of meetings together they checked the accuracy of each other's notes and refined their note-taking procedures. Used constant comparison techniques

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				recovery-based principle/practice, that reflected a need for more information, or that was an example of a trainee's use of recovery-orientated practice were coded to identify broad categories. The inputs were then categorised into the different categories. The researchers also noted whether the inputs were an example of the staff member's work, comments about a client or simply reflected a more general experience. They also noted whether the input affirmed the value of recovery, suggested a		management? 2) My clients won't admit to having a mental illness 3) Crises prevent us from using recovery 4) Recovery means working with client-centred goals 5) Developing the recipient's goals (reflects the need but also the challenges of working with goals) 6) Whose goals? (use of system-derived goals rather than client-centred goals). 7) Making a good connection 8) Who should do what? 9) Symptom dominant vs. holistic views of the clients, and 10) wellness works (reports of using the	in analysis. Two researchers independently coded the transcripts from two of the sessions into the ten categories. Researchers achieved 80% agreement after the first transcript and this moved up to 87% with the second transcript. The validity of the ten categories was checked against data from two days of training in another state. Explored perspectives along recovery orientation continuum.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				struggle with working within recovery, or objected recovery or its applicability. Finally, they noted whether the input was made during introductory sessions or in follow-up sessions when it was hoped that trainees would have implemented wellness management or some recovery principles in their practice.		tools presented in the wellness management training program). A majority of the trainees' comments fit positively with recovery. The most positive inputs were those in describing service users in holistic terms and using techniques to achieve client-centred goals. Challenges were around establishing collaborative relationships with clients, especially those who deny having a mental illness. A subset of trainees did not seem able to abandon their notions about the primacy of medication and ADL improvement. Similarly, other	

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
						trainees held the view that some of their clients were too sick for recovery.	
6	1578	SULLIVAN2013	USA	Semi-structured interviews were carried out with case managers. Each respondent was asked to describe the characteristics of the clients they served, aspect of the job they liked/disliked and their beliefs about the concept, process and possibility of recovery from mental illness. Data was analysed in parallel such that as interesting themes arose, these could be further explored in subsequent interviews. Based	50 case managers working with adults with SMI were recruited from nine urban and suburban community mental health teams. Only 40 interviews were included in the analysis, either because of technical difficulties or because it transpired that the case managers worked with children.	1) Low hope (N=6) case managers, who expressed little hope that recovery from mental illness was possible tended to view recovery as synonymous with "cure". These case managers emphasised their role in helping to stabilise clients. 2) Moderate hope (N=12) case managers viewed recovery as gains in symptom management and social functioning and talked about the importance of patient insight and treatment compliance for	12/18 = Mid quality Convenience sample in restricted geographical area. Carried out 9 interviews with ineligible participants! Addressed inter-rater reliability by monitoring congruence between stated hope in recovery and 'recovery' practice examples. Offers new classification of clinicians re: hope and how levels of hope affect practice.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				<p>on the respondent's answer to "Do you think the clients on your caseload can recover"</p> <p>transcripts were assigned to one of four levels of hopefulness (low, moderate, hopeful and high). Differences in the understandings of recovery and reported recovery-promoting behaviours were examined across these different levels of hopefulness.</p>		<p>recovery.</p> <p>3) Hopeful case managers' (N=8) definition of recovery mirrored current perspectives of the concept and was viewed as individually determined. Compared to the low hope group, control of the case management process has shifted from the professional to the consumer, who in turn is seen as capable of taking an active part in decisions that are critical to their well-being.</p> <p>4) The high hope group (N= 14), consistently defined recovery as the ability of consumers to accomplish</p>	

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
						personal goals, and when describing their work emphasised the importance of a person-centred philosophy.	
7	1808	SULLIVAN2012	USA	Semi-structured interviews were carried out with case managers. Each respondent was asked to describe the characteristics of the clients they served, aspects of the job they liked/disliked and their beliefs about the concept, process and possibility of recovery from mental illness. Data was analysed in parallel such that as interesting themes arose, these could be further explored in	50 case managers working primarily with adults with serious mental illness. They were recruited from nine urban and suburban community mental health teams across two states. Only 40 interviews were included in the analysis, either because of technical difficulties or because it transpired that the case managers worked with children.	The main themes which characterise the helping relationship from the staff perspective were 1) engagement (listening to clients, seeing them as a person not a diagnosis, using the principles of client-centred planning and self-determination) 2) pushing, pulling and letting go (striking the right balance between helping the client without being too controlling and how this dynamic changes over the	11/18 = Mid quality Study aims not clear. Large sample. No information on sampling strategy. No discussion of ethical issues.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				subsequent interviews. The focus of the analysis was on the process of helping, specifically the use of the professional relationship and other key elements of direct managers identified as relevant to working with this clientele. Each interview was coded by two reviewers using deductive framework initially and then using inductive coding.		course of the relationship), 3) moving forward (instilling hope, talking about goals and recovery) 4) building on the relationship (being a stable presence in a client's life whilst maintaining boundaries and not becoming too enmeshed). The authors argue that case management requires complex and nuanced professional skills.	
8	2814	RICE2009	USA	Interviews and an interpretive phenomenological approach was used to understand the experiences of cases managers in delivering care to women diagnosed	11 case managers were recruited from a community mental health centre that serves people diagnosed with severe mental illness.	The main themes which emerged from the data were that 1) case managers viewed themselves as being supportive 2) they felt overwhelmed and frustrated with their	4/18 = Low quality Very little information provided on analysis strategy. Limited scope for drawing wider inference. Research and sample design not defended.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				with schizophrenia.		jobs, particularly they struggled to apply the tenets of recovery and understand their role in the process for women who have experienced violence and poverty in their lives.	Quality of data collection and analysis not reported.
9	1152	WATSON2011	USA	Ethnography using semi-structured interviews to examine meanings of recovery in New Mexico in light of a major state-wide reform of mental health services. The interview schedule included prompts for providers to share their thoughts and attitudes about official calls for recovery-orientated services. The interviews were	109 interviews were carried with frontline adult mental health service providers in 14 community-based agencies across 6 counties in New Mexico. Six of the agencies were community mental health centres, three were substance abuse treatment centres, two were specialist outpatient services for homeless adults with co-	The major themes discussed were: 1) lack of clarity about the meaning and implementation recovery, 2) conflation of recovery with full symptomatic remission and scepticism that the latter is possible, 3) recovery as a rhetorical device that draws attention away from necessary infrastructure changes and driven by profit motives	8/18 Mid quality Large sample using purposive sampling. Identified capabilities approach - but unclear how this came from analysis – bit of a leap. Reflexivity, ethics and auditability not addressed.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				coded using a framework based on the specific questions and broader domains that made up the interviews.	occurring disorders and three were small group practices. The interviews took place between April and December 2006.	that underlie privatised managed care systems, 4) personal experience as a form of expertise in clinical settings and 5) stigma and discrimination as barriers to recovery. The authors argue that the term recovery serves as a symbol with many meanings, which can change depending on the desired agenda.	
10	5078	ROGERS2007	USA	Three work-groups were formed at a conference to discuss practice issues in recovery. The main topics addressed by the groups were their barriers experienced in promoting recovery and recommendations	The conference took place over one day in January 2006 in Philadelphia and was attended by 24 psychiatrists from institutional and community settings who were clinicians, administrators, and educators.	Twelve barriers were identified which fell into three categories 1) psychiatry knowledge, roles and training 2) transforming public health systems 3) environmental barriers to opportunity.	2/18 = Low quality Research design is not defensible - one day symposium/discussion. Credibility of findings is questionable. Study is poorly reported (brief report) – no mention of sample design, sample composition, quality of data collection and

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				for change. The barriers and recommendations were documented and discussed in a final meeting attended by all participants. Thematic analysis was used to classify the barriers into categories.		Participants made 22 recommendations to address these barriers through changes in policies, programs, psychiatric knowledge and practices.	analysis. Reflexivity, ethics and auditability not addressed.
11	7704	DUNLAP2009Thesis	USA	Used phenomenology to uncover the lived experience of social workers as they created and implemented discharge plans within the recovery perspective. In-depth interviews captured the social workers' experiences regarding the discharge process, with an emphasis on stigma,	8 Social workers were selected through a convenience sample using a snowball technique. The selected sample was a purposeful sample. The inclusion criteria specified that participants were a licensed social worker with one year of experience post graduation. In addition, to ensure	The analysis describes the unique lived experience of participants creating and implementing the discharge plan. The analysis found two essential structures named 1. Competing priorities 2. Conflict. Four key components within the essential structures were	14/18 = High quality Space to report study in full – dissertation thesis. Phenomenological inquiry. Negative case sampling evident. Ethical considerations not reported.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				resources, and the integration of the recovery process. Each interview lasted between two and three hours. A retrospective review was a second method of data collection whereby participants completed an anonymous retrospective review of the last 10 discharged clients (data collected within one week of the interview). Questions included date of first discharge discussion, whether stigma was addressed, whether the client agreed with the plan, and self-	a recovery perspective, the participants must have received training on the recovery perspective. The eight participants consisted of six females and two males. Seven participants were white and one participant was of Asian descent. Of the social workers included in the study, the years of experience varied from 5 years to 35 years.	identified a. sharing and creating power b. experiencing loss c. feeling competent d. handling conflict. The analysis of the key components identified that participants described competing dual responsibilities in the discharge planning process. To reduce role conflict, participants expanded their definition of discharge planning success to include the completion of the treatment goals as well as linkages to external supports.	

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				rated outcome of the discharge plan.			
12	1321	COURTNEY2013	AUSTRALIA	In-depth, semi-structured interviews were conducted to explore how social workers manage the tensions of working within a recovery-orientated approach with involuntary clients on Community Treatment Orders. The interview schedule asked participants to describe their practice approaches and the principles that guide their work with involuntary clients, their understanding of recovery, how they manage their work with involuntary clients including	Interviews were carried out with 10 social workers recruited from a variety of community mental health teams in Adelaide. Participants had varying levels of work experience in mental health ranging from 1-15 years.	Three core themes were identified 1) embedding involuntary treatment within a recovery approach (e.g. communicating in a non-authoritarian way, building a positive relationship) 2) professional resistance and managerial agendas (attitudes of non-social work colleagues, the dominance of the biomedical model in multi-disciplinary teams, the view that recovery is used as a means of removing responsibility from themselves and putting it onto the clients)	11/18 = mid quality Position research within an epistemology (social constructionism), but no evidence of theoretical position influencing study design, analysis etc. Some discussion of social work values and recovery values – assuming authors are social workers.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				<p>how they manage and overcome any challenges. Thematic analysis was used to analyse the interviews. Whilst the analysis was primarily inductive, a framework of recovery principles (Davidson et al., 2005; the development of new meaning and purpose, valuing lived experience, overcoming disability, developing relationships, challenging discrimination, the development of agency and empowerment) was later applied to the data in order to determine which recovery principles the social workers</p>		3) challenging resistance and enhancing self-determination (building an element of choice into CTOs)	

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				were drawing on.			
13	263	VANLITH2009	AUSTRALIA	Phenomenological open-ended interviews were, conducted with art facilitators to elicit their conceptualisations, experiences and reflections of the contribution of art making to recovery. The data was analysed using IPA.	Three facilitators were recruited from different community-based art making programs in Australia.	Eight themes and three domains emerged from the data. The first domain was the skills, qualities and approaches of the facilitator seen to help recovery which included a) active witnessing and beliefs in the client's creative emergence, b) creating learning opportunities, and c) providing a space to experiment. The second domain identified the ways in which art making can be a transformative experience for clients which includes a) transcendence and satisfaction b) self-reflection	11/18 = Mid quality Described as a pilot study Detailed profile of sample Evidence of IPA use – context retained in analysis. Small sample. Reflexivity, ethics and auditability not reported.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
						c) giving form to feeling. Finally, the third domain related to how art making assisted the individual to connect with the world by a) generating passion and meaning b) creating relationships with others.	
14	2	CLEARY2013	AUSTRALIA	Interviews were carried out with acute inpatient mental health nurses to explore their understanding of recovery and how they incorporate the recovery paradigm into practice. The interview guide was developed following a literature review and discussions	21 nurses working in one of four acute inpatient mental health services were recruited. Data collection continued to theoretical saturation.	Three main themes emerged: 1) perception of recovery The most prominent perception of recovery was that of holism where social factors, psychological factors and living skills were viewed as important to recovery. Other perceptions of recovery were also discussed.	7/18 Mid quality Convenience sample used. Two members of the research team analysed the data. No mention of data management method. Limited analysis presented without discussion of how concepts were constructed. Categories not illustrated with quotes.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				with the research team. Responses were analysed using thematic analysis.		<p>2) humanism When asked about the most important contribution nurses make to recovery, responses primarily clustered around the notion of humanistic interpersonal nursing such as developing therapeutic relationships, being kind, discussing options etc</p> <p>3) practical realities Nurses reported that they support recovery (in order of frequency) using medication, education, goals/discharge planning, interpersonal relationships, and social and practical aspects of daily living.</p>	
15	Expert	HUNGERFORD2013	AUSTRALIA	Single-case	Participants were	Two major themes	10/18 = Mid quality

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				<p>embedded study. Focus groups were conducted to assess staff experiences of the implementation of recovery support. One semi-structured interview was carried out with a participant who did not feel they would be able to respond honestly or openly in front of other group members. The focus group/interview schedule was the same across groups and asked participants to discuss their experience of the implementation of recovery support; the benefits and challenges of this process; and their ideas on how the</p>	<p>recruited from a single public mental health service in Australia in 2010. Four focus groups were conducted for each; nurses, occupational therapists, social workers and psychologists (approx. 3 participants per group). A separate focus group for managers was conducted including both area-wide and front-line managers (N=5). It is unclear how many people participated in total.</p>	<p>were identified; “change management” and “work practices”. “Change management” describes the tension between practitioners and managers in the implementation of recovery support. Many practitioners felt frustrated at the top-down approach taken by managers and their failure to acknowledge that recovery is not a new concept for them. Meanwhile managers believe that practitioners are pessimistic and their past practices less than satisfactory. “Work practices” describes the view held by practitioners that a lack of community-</p>	<p>Detailed profile of achieved sample not reported. The interviews were analysed independently by two researchers who then compared their results (unclear how any disagreements were resolved).</p>

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				process might have been or could be improved. Each of the transcripts were analysed independently to identify the emerging themes, which were then refined and comparatively analysed across the groups.		resources, under-staffing and too much paperwork challenge the implementation of recovery. In contrast, managers viewed these concerns as symptoms of anxiety amongst practitioners about the changes occurring.	
16	2016	BATTERSBY2012	CANADA	This study is a feminist- informed ethnography. Methods included conducting interviews and focus groups with staff and service users. The aim of the research was to produce descriptions of what happened to people during the process of being transferred from a large institution	44 individual interviews and 3 focus groups were carried out with mental health managers and staff working in tertiary and community-care facilities in one of two towns.	Individuals who had been involved in the initial planning of the new facilities described how they had hoped to implement psychosocial rehabilitation within the context of a recovery philosophy that created space for maximum patient autonomy and decision making. However, they also reported	14/18 = High quality Large diverse sample. Part of a wider ethnographic study. Clear theoretical underpinning. Report combines findings and discussion sections. Weak conclusion.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				<p>which was closing down to recovery-orientated tertiary and community-based facilities. Data from the ethnography were organised and coded into emergent themes. Gender-based and intersectional analytic frameworks were also applied to pose questions about the similarities or differences among the needs of women and men.</p>		<p>that this would be a challenge given the level of need amongst people who have been long-term institutionalised. There was evidence to suggest that the staff found it difficult to move away from a more custodial model of care in practice. This was also true for service managers who struggled with letting service users make decisions while assessing their own risk management and legal responsibilities. Interviews with staff reflected inconsistencies in the understanding of recovery. For example, staff</p>	

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
						believed that PSR did not apply to service users who were too ill (which conflicts with the values of PSR and recovery).	
17	6954	SCHWARTZ2013	CANADA	In line with the principles of participatory action research, the participants agreed on the research design together and decided to use narrative phenomenology. Participants met up for weekly discussion groups for 10 weeks and generated stories about recovery from provider and consumer perspectives. They dialogued about the values underlying the stories to understand what	The sample consisted of 10 stakeholders (3 consumers, 2 qualified peer support workers, 3 occupational therapists, 1 psychiatrist and 1 clinician-researcher. In line with participatory action research the sample consisted of the participants who had raised the initial research question from an outpatient mental health clinic at a university hospital.	The central themes were a) relational space (boundaries, relationships, limited resources, shifting roles, power) b) obstacles (stigma, culture, fear of exposure); c) meaning making (what is recovery?). Providers frequently voiced stories about the intrapersonal conflict between the "need to protect and the desire to support consumer autonomy. Another tension underlying provider stories was between the desire	7/18 = Mid quality Brief report of preliminary findings. Provide a summary of main themes without quote illustrations. No attention to reflexivity, ethics or auditability.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				really matters in recovery. The sessions were transcribed and analysed for themes.		for connection with consumers and the need to “maintain professional boundaries.”	
18	Web of Science Citation search	KIDD2014	CANADA	Pre- post- test experimental design using mixed methods. The intervention was a series of talks to staff by 12 former patients. At post-test focus groups were carried out with the participants in the intervention group about their experiences with the speaker series and the data was analysed using content analysis.	20 staff working in one of 6 inpatient units in a large urban psychiatric facility in Canada. The units were matched as closely as possible according to average length of stay and one unit from each pair randomly allocated to either the intervention (series of talks) or the control group.	Staff who had attended the talks showed a significant increase in recovery knowledge, which was not evident in the control group. This is thought to reflect a greater understanding that recovery is nonlinear and can include a number of different pathways and resources. Two themes emerged from the qualitative data: 1) the talks gave staff hope, both for clients and for their role and 2) they spurred staff to reflect on their	8/18 = Mid quality Qualitative component of mixed methods study reported in brief. Limited quotes. Unclear how conclusion is derived from data.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
						practice. Overall, staff had a greater appreciation for the potential of inpatient clients and a greater recognition of the importance of engaging clients at a human level by recognizing their individuality and treating them with respect.	
19	1946	PIAT2012	CANADA	Focus groups were conducted and participants were asked a series of open-ended questions: How do you define recovery? How do the services provided by your team reflect recovery-orientated practice? And, how is recovery-orientated practice part of your day to	The nine focus groups were conducted with a sample of 68 service providers recruited from three Canadian sites. At the time of the study, all three sites were in the early stages of implementing recovery-orientated practice into their organisation. The participants were	Three major themes were identified 1) Service providers had positive attitudes towards recovery-orientated reform (e.g. a better way of delivering services, represent a change in the power relationships focus) 2) some expressed scepticism (e.g. just another buzzword, doesn't contribute	14/18 = High quality Sample included a range of stakeholders/levels of delivery. The data analysis was carried out by the team and involved constant team discussion to ensure agreement.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				day work? A socio-demographic questionnaire was also administered at the start of each group. The data was first coded according to two broad themes: 1) reacting and responding to recovery-orientated practice, and 2) implementing recovery orientated practice. The data was then coded inductively using an open coding process and themes were identified.	staff providing direct service to people with serious mental illness (e.g. social workers, psychologists, occupational therapists) at various levels of service delivery (e.g. frontline, clinical supervisors, team leaders, managers) and working in diverse settings (inpatient and outpatient).	anything new to practice). 3) challenges associated with the implementation of recovery (e.g. the conceptual uncertainty and consistency regarding the meaning of recovery, limited organizational support and leadership, the applicability of recovery to certain populations, bureaucratic burdens of recovery and stigma/social exclusion of people with mental illness).	
20	Hand search of included references	NG2008	HONG KONG	Focus groups were conducted to examine trainee psychiatrist views of recovery from schizophrenia. The interview schedule was developed by	Two focus groups were conducted with 12 trainee psychiatrists working in various psychiatric units in Hong-Kong. One group contained	Four themes emerged 1) Absence of relapse is a pre-requisite for recovery 2) recovery means different things to	9/18 = mid quality Data management method not reported. Ethics e.g. consent procedures not mentioned. Some reporting of limitations

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				a team of mental health professionals and included questions such as “How do you define recovery from schizophrenia?”, “Do you think patients suffering from schizophrenia can fully recover?” and “What can others do in promoting their recovery?”. Transcripts were analysed using content analysis.	newly trained psychiatrists with less than two years clinical experience (n=6) and the other with more experienced psychiatrists who had five or six years of experience (n=6).	different people at different stages of illness 3) Recovery is an important agenda item (but for most participants this meant discussing medication use and risk of relapse). 4) recovery in the presence of persistent symptoms (this was more often endorsed by junior psychiatrists). The central theme encompassing the four categories was that recovery is a process that is complex and difficult to define.	of study.
21	863	KAEWPRO2011	THAILAND	Semi-structured interviews were conducted in which nurses were asked to share their opinions about recovery from	24 mental health nurses were recruited from two general hospitals and one psychiatric hospital in	Views of recovery support were characterised by a focus on clinical and functional improvement, notably symptom	7/18 = mid quality Purposive sampling. Analysis weak – no attention to negative cases. Conclude that nurse

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				schizophrenia, as well as the factors that are involved in recovery. The data was analysed using thematic analysis.	Thailand. For inclusion, nurses needed to have been providing care for at least one year to people with a diagnosis of schizophrenia. The nurses' experience ranged from 3-27 years.	remission, an ability to carry out activities of daily living and a return to work or study. Four themes described the factors thought to be involved in the recovery process 1) personal facilitators (hope, acceptance, and treatment adherence) 2) environmental facilitators (family, a supportive community, good access to mental health services) 3) personal barriers (poor adherence to medication, illness-related factors) 4) environmental barriers (stigma, lack of integration of mental health services).	understanding is dominated by clinical recovery examples – unsure that this accounts for all the data.
22	9399	CONE2012	NEW	Focus groups and	10 occupational	The main themes	6/18 = Low quality

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
			ZEALAND	interviews were conducted to explore how occupational therapists incorporate the recovery approach into mental health practice. The interview guide included: how do you incorporate the recovery approach into your practice? What facilitated and what challenged the incorporation of the recovery approach into practice? How do you use occupations to facilitate recovery, to empower people and inspire hope? How is the recovery approach useful and/or not useful in the New Zealand context?	therapists working in New Zealand were recruited, and allocated to one of two focus groups to ensure that a diversity of work experience and settings were represented. Three participants were then purposely selected from the focus group for in-depth follow up interviews based on their professional experience and contributions to the emerging main themes.	discussed were incorporating the recovery approach into practice, philosophical congruence supports recovery orientated practice and challenges with incorporating recovery into practice. Overall, the occupational therapists incorporated recovery into their practice in a variety of ways, notably through the process of facilitating occupational engagement on the ward, in the community and on an ongoing basis in life. They perceived the recovery approach to be an integral part of occupational therapy practice in	Sampling method and details of settings, and participant characteristics not reported. Weak analysis – Diversity and multiple perspectives not described. Study limitations addressed e.g. gaps in sample.

#	Database ID	Study ID	Country	Method	Participants/ Setting	Main Findings	Quality rating
				Thematic analysis was used to code the data.		mental health, but acknowledged that this could be challenging.	

Appendix 20 Staff Understanding of Recovery-orientated Practice: Full coding framework

Overarching Category: Staff Role Perception

1.1 *RECOVERY SUPPORT IN INSTITUTIONALISED SYSTEM*

1.1.1 *Hierarchy, medical language and clinical tasks*

1.1.1.1 Psychiatric power

1.1.1.2 Changing language to support recovery

1.2 *JOB VALUE*

1.2.1 *Job or vocation*

1.2.2 *Recovery match with professional philosophy*

1.3 *PERSONAL VALUES AND QUALITIES OF STAFF*

1.3.1 *Reflexivity*

1.3.1.1 Remaining involved

1.3.1.2 Power shift

1.3.2 *'Specialist' knowledge and skills*

1.3.2.1 Discrepancy between training and practice

1.3.2.2 Balancing competing demands

1.4 *EXPECTATIONS OF SERVICE USERS*

1.4.1 *Preparedness to change practice*

1.4.1.1 Service user or system led

1.4.1.2 Empowering service user interactions

1.4.1.3 Viewing service users as individuals

1.4.1.4 Encouraging service users to take more responsibility

1.4.1.5 Service user involvement

1.4.1.6 Service user leadership

1.4.2 *Retaining status quo*

1.4.2.1 Maintaining the power imbalance

1.4.2.2 Not good to have high expectations of clients

1.4.2.3 'Recovery' is something staff do

Sub-category: Clinical Recovery

2.1 *DEFICIT PERSPECTIVE*

2.1.1 *Focus on problems, diagnosis and symptoms*

2.1.2 *Custodial model of care*

2.1.2.1 Conflict between recovery values and medical values

2.1.3 *Influence of in-patient setting*

2.2 *MEDICATION ADHERENCE*

2.3 *SYMPTOM REMISSION*

2.4 *GAINING INSIGHT*

2.4.1 *Recovery means living with illness*

- 2.5 *ABSENCE OF RELAPSE*
 - 2.5.1 *Move from maintenance to improvement*
 - 2.6 *RISK MANAGEMENT*
 - 2.6.1 *Crisis management dominates*
 - 2.6.1.1 *Balancing risk, needs and aspirations*
 - 2.6.1.2 *Recovery goes beyond crisis management*
 - 2.6.1.3 *Supporting risk within legislative frameworks*
 - 2.6.2 *Support recovery or manage risk*
 - 2.7 *MEET BASIC SURVIVAL NEEDS*
 - 2.7.1 *Recovery is getting back into life*
 - 2.8 *ADL TASK MASTERY*
 - 2.8.1 *Independent living*
 - 2.9 *STABILISING OR FIXING PATIENTS*
 - 2.9.1 *Getting back to how you were before illness*
-

Sub-category: Personal Recovery

- 3.1 *HOLISTIC APPROACH*
 - 3.1.1 *Client-centred goals*
 - 3.1.1.1 *Service user autonomy and decision making*
 - 3.1.2 *Physical healthcare*
 - 3.1.3 *Psychological therapies*
 - 3.1.4 *Meaningful activity*
 - 3.1.5 *Social inclusion*
 - 3.2 *SELF MANAGEMENT*
 - 3.2.1 *Peer support*
 - 3.2.2 *Stress management*
 - 3.2.3 *Strengths based approach*
 - 3.3 *QUALITY OF LIFE*
 - 3.3.1 *Promoting citizenship*
 - 3.3.2 *Supporting hope*
 - 3.3.2.1 *Advocacy*
-

Sub-category: Service-defined Recovery

- 4.1 *OWNED BY THE ORGANISATION*
 - 4.1.1 *Contractual objectives take primacy*
 - 4.1.1.1 *Competing government and commissioning priorities*
- 4.2 *ADMINISTRATIVE/FINANCIALLY DRIVEN GOALS*
 - 4.2.1 *Financial stability*
 - 4.2.1.1 *Maintaining funding priorities and commissioning demands*
 - 4.2.2 *Risk to organisation if targets not met*
- 4.3 *A TOOL TO REDUCE COSTS*
 - 4.3.1 *Competing savings programmes*
 - 4.3.2 *Demands of increasing activity targets*

4.4 *SERVICE THROUGHPUT OR MOVING-ON*

4.5 DISCHARGE

4.5.1 *Outcomes orientation*

4.5.1.2 Recovery as service outcome

4.6 *REDUCING SERVICE ACCESSIBILITY*

4.6.1 *Eligibility for recovery-orientation*

4.7 SETTING LIMITS ON SERVICE PROVISION

4.7.1 *Efficiency and productivity*

4.7.1.1 Performance and compliance targets

APPENDIX 21 Publications resulting from thesis PDF documents (n=3) attached

LE BOUTILLIER, C., LEAMY, M., BIRD, V. J., DAVIDSON, L., WILLIAMS, J. & SLADE, M. 2011. What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric Services*, 62, 1470-1476.

LE BOUTILLIER, C., SLADE, M., LAWRENCE, V., BIRD, V. J., CHANDLER, R., FARKAS, M., HARDING, C., LARSEN, J., OADES, L. G., ROBERTS, G., SHEPHERD, G., THORNICROFT, G., WILLIAMS, J. & LEAMY, M. 2015. Competing Priorities: Staff perspectives on supporting recovery. *Administration and Policy in Mental Health and Mental Health Services Research*, 42, 429-438.

LE BOUTILLIER, C., CHEVALIER, A., LAWRENCE, V., LEAMY, M., BIRD, V., MACPHERSON, R., WILLIAMS, J. & SLADE, M. 2015. Staff understanding of recovery-orientated mental health practice: a systematic review and narrative synthesis. *Implementation Science*, 10.